STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING

1:00 P.M.

Monday, January 5, 1998

Chamber of Commerce Building
1201 K Street
12th Floor Conference Room
Sacramento, California

REPORTED BY:
Jennifer Arroyo
CSR No. 10696
Our File No. 42160

APPEARANCES:

Chairman Alain Enthoven, M.D.

Executive Director Philip Romero, Ph.D.

Deputy Director Alice Singh

Deputy Director Hattie Skubik

Members

Bernard Alpert, M.D.
Rodney Armstead, M.D.
Rebecca Bowne
Donna Conom, M.D.
Barbara Decker
Nancy Farber
Jeanne Finberg
Martin Gallegos
Bradley Gilbert
Diane Griffiths
Terry Hartshorn
William Hauck
Mark Hiepler
Michael Karpf, M.D.
Clark Kerr
Peter Lee
J.D. Northway, M.D.
Maryann O'Sullivan
John Perez
John Ramey
Anthony Rodgers
Helen Rodriguez-Trias
Les Schlaegel
Ellen Severoni
Bruce Spurlock, M.D.
David Tirapelle
Ronald Williams
Allan Zaremberg
Steven Zatkin

Ex-Officio

Kim Belshe
Marjorie Berte
Herschel Rosenthal
Michael Shapiro
David Werdegar

I N D E X

CHAIRMAN ENTHOVEN: I'd like to welcome all of you back and wish all of you a very happy new year. Thank you very much for coming. We're now approaching the end of this interesting road. I'd like to begin by calling the meeting to order.

Will Ms. Stephanie Kauss of the Task Force staff please call roll.

MS. KAUSS: Alpert?

DR. ALPERT: Here.

MS. KAUSS: Armstead?

DR. ARMSTEAD: Here.

MS. KAUSS: Bowne?

MS. BOWNE: Here.

MS. KAUSS: Conom?

(No audible response.)

MS. KAUSS: Decker?

(No audible response.)

MS. KAUSS: Enthoven?

CHAIRMAN ENTHOVEN: Here.

MS. KAUSS: Farber?

MS. FARBER: Here.

MS. KAUSS: Finberg?

MS. FINBERG: Here.

MS. KAUSS: Gallegos?

(No audible response.)

MS. KAUSS: Gilbert?

DR. GILBERT: Here.

MS. KAUSS: Griffiths?

MS. GRIFFITHS: Here.

MS. KAUSS: Hartshorn?

MR. HARTSHORN: Here.

MS. KAUSS: Hauck?

(No audible response.)

MS. KAUSS: Hiepler?

(No audible response.)

MS. KAUSS: Karpf?

(No audible response.)

MS. KAUSS: Kerr?

MR. KERR: Here.

MS. KAUSS: Lee?

MR. LEE: Here.

MS. KAUSS: Northway?

(No audible response.)

MS. KAUSS: O'Sullivan?

(No audible response.)

MS. KAUSS: Perez?

(No audible response.)

MS. KAUSS: Ramey?

(No audible response.)

MS. KAUSS: Rogers?

(No audible response.)

MS. KAUSS: Rodriguez-Trias?

DR. RODRIGUEZ-TRIAS: Here.

MS. KAUSS: Schlaegel?

MR. SCHLAEGEL: Here.

MS. KAUSS: Severoni?

MS. SEVERONI: Here.

MS. KAUSS: Spurlock?

DR. SPURLOCK: Here.

MS. KAUSS: Tirapelle?

MR. TIRAPELLE: Here.

MS. KAUSS: Williams?

(No audible response.)

MS. KAUSS: Zaremberg?

(No audible response.)

MS. KAUSS: Zatkin?

MR. ZATKIN: Here.

MS. KAUSS: Belshe?

MS. BELSHE: Here.

MS. KAUSS: Berte?

MS. BERTE: Here.

MS. KAUSS: Knowles?

(No audible response.)

MS. KAUSS: Rosenthal?

SENATOR ROSENTHAL: Here.

MS. KAUSS: Shapiro?

(No audible response.)

MS. KAUSS: Werdegar?

MR. WERDEGAR: Here.

MR. SHAPIRO: Shapiro here.

MS. KAUSS: Thank you.

CHAIRMAN ENTHOVEN: We do have a quorum of 16 members. I want to especially thank the devoted 16 who came to join us. Each member has before herself

or himself a copy of the Governmental Oversight of Managed Health Care and the Expanding Consumer Choice with Health Plans background papers. All the other background papers were Federal Expressed to members earlier this week.

I'd just like to take the opportunity to thank our staffs, both at Stanford and Sacramento, for the heroic work they did over the holidays to turn out all of these documents accurately, carefully, thoroughly research. And I want to thank the Task Force members who spent hours on the telephone talking with them approving the summaries of their statements and the like.

Members now have all the components of the main report before them. The draft Executive Summary, the draft of the Chairman's letter, all adopted findings and recommendations sections, the letters submitted by members on various issues surrounding the Task Force.

If there are any questions about technical aspects surrounding the publishing of the report, Alice Singh has kindly volunteered to answer them. Do we need to review the process by which this will all be published? We discussed it before, and it's all been laid out in our rules. We've had 12 business meetings, 5 study sessions, and 6 public hearings from April, 1997, to today.

I would like at this time to introduce

Senator Rosenthal who would like to make a brief statement. Senator Rosenthal, welcome to our Task Force, Senator.

SENATOR ROSENTHAL: Thank you very much. I wanted to thank the Chair and the executive director for letting me speak this time. The Senate is going into session at 1:30, so I'll be leaving here as soon as I make my statement.

First of all, I wanted to congratulate all of you for your dedication and hard work as Task Force members. I welcome and support your thoughtful, however in my opinion, modest recommendations. I hope you enjoyed working with Michael Shapiro, my staff director as much as I do. He keeps you on your toes as he does me. And I hope you have a greater appreciation of the challenges and the frustrations that the legislators face when they seek to enact consensus managed care initiatives.

I must say that I am disappointed but not surprised by the final task report. From consumer's protection point of view the report falls short of what is needed. The composition of the Task Force dominated by the governor's appointees made this a somewhat predictable outcome. I believe the Task Force dominated by legislative appointees would have reached far different conclusions. What that says to me is that the Task Force report is a starting point, which must be augmented to reach adequate protection for consumers of

managed care.

I want to highlight three points. First, as you know, the Task Force report is not comprehensive. For example, I have a number of HMO Bills on hold that include issues that were not subject to Task Force recommendations. Therefore, I believe it is important for the Task Force in its transmittal to the governor and the legislature to reaffirm its August the 7th, 1997, statement indicating that you did not review individual HMO Bills pending in the legislature, and that you support such Bills being considered on their merits, and that the Task Force report should not impede that legislative process.

Second, based on the minority report letters submitted by some Task Force members, I anticipate significant industry opposition even to these modest recommendations based on the absence in the report of cost benefit analyses. Then the issue should not be used to further stall HMO reforms.

In November of 1997, the Kaiser Family Foundation issued a report development of Price Waterhouse on impact of five HMO Bills on health plan premiums. One of the Bills reviewed where they found minimal cost was my measure SB625 dealing with HMO drug formularies. I've been informed by the Kaiser Family Foundation that it is exploring a proposal to do similar cost benefit analyses on the major recommendations in the Task Force report, and that such recommendations

will be available in the next few months. That means we will have an objective credible cost information during our legislative deliberations on Task Force related Bills. Finally, this morning I joined a press conference with Senator Gallegos where he called for another addition to adopt major HMO reforms that were done by the Task Force.

I want to indicate that I see the initiative process as a last resort. My immediate goal is to negotiate Bills in good faith with the governor on Task Force recommendations. In particular, I will insist on those negotiations on the creation of an independent HMO Board to regulate managed care plans.

Mr. Gallegos and I have HMO Board legislation and conference committee, in other words, Bills that have passed both Houses with bipartisan support which are ready for the governor's signature. If there is a veto of this proposal, then I assume we may have to take the critical issue to the vote of the people. I'm willing to live by their decision.

In closing, I want to again thank you all. I imagine I'll be seeing some of you during the legislative deliberations on the Task Force recommendations. I look forward to working with you on my turf, the legislative process, and finally a happy new year to everyone. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much, Senator. Next, we will have the Executive Director's

report.

DR. ROMERO: Thank you, Mr. Chairman.

In this meeting, we come to the end of a long journey. Many of us volunteered, but some of us were drafted. All of us worked extremely hard and put our passion into our common effort.

I want to stress that last phrase, "common effort." You all know how disparate are the points of view represented on this group. In fact represented in the contrasts of Senator Rosenthal's statement and this statement. You can recall the degree of mutual suspicion that existed when we began our work eight short months ago. Contrast that to the shared sense of mission that you developed in those months, that allowed you to produce over 100 recommendations. Taken together, your proposals, well in my opinion, help restore Californians' trust in their health care system.

Now, just about everyone inside and outside this Task Force will find your product lacking in some way. I, for instance, greatly regret that we did not have the time or resources to quantify the impacts of these recommendations, as Senator Rosenthal just alluded to, both the costs in terms of increases in healthcare spending, but also the benefits in terms of increased consumer satisfaction and trust in the system. But while it's human nature to dwell on what might be missing, it's important that we do not obscure the important elements that you created.

My own personal list of the "crown jewels" of your recommendations include the following: Risk adjustment: This is a subtle one because it depends upon use of statistical tools that few laymen understand and some specialists believe are not yet adequately developed. But it will hold plans and providers financially harmless if they cover and treat patients who are sicker than average, and so eliminate important perverse incentives to favor the well and ignore the sick.

Disclosure and Standardized reference contracts: Many of your recommendations put more information in the hands of consumers without which the competitive market can't really function. By requiring that plans present their offerings in the same format as several standard reference contracts, consumers can make meaningful comparisons, know what they are buying, and need not be inhibited by ignorance from leaving a plan with which they are unsatisfied. You've also proposed that plans disclose to enrollees how their provider is compensated.

Improving the Grievance Process: You've recommended an independent third-party review process for disputes over medical necessity, and recommended that plans be required to pay for second opinions.

Continuity of Care: You've recommended that patients with chronic or acute conditions be permitted to continue seeing a deselected provider for

up to 90 days.

Preauthorization: You have proposed that providers who follow treatment protocols and have good outcomes be exempted from preauthorization requirements.

Consolidating Regulation: You have proposed that the current dispersion of state authority to regulate pieces of the managed healthcare system be consolidated into a single regulator. You further recommended that the regulator should have a broad jurisdiction, but you recognize that reorganizations are complex and error-prone, so you propose that the consolidation be phased in over several years.

Much has been made in the press of your agreement to disagree over whether this regulator should be led by one or by five people. The presses failed to note that your proposal would consolidate such a wide range of regulatory authority was a very controversial, courageous and forward thinking decision.

And finally Quality of care: Beyond the important elements I've already mentioned, you've made recommendations of a variety of smaller actions to assure that more and more medicine is practiced using objective, evidence-based tools and data.

I want to note that all of these "crown jewels" passed by very lopsided votes, at least four to one, and often unanimously.

So I encourage you to view your work in its very considerable totality. For instance, I'm told

that the scope of your work is substantially broader than the President's analogous commission. In my view, the glass is definitely not half-empty, it's more like 90 percent full.

While, each of you probably identified elements of this package with which you probably disagree, or agree to only with reservations, I think each of you should feel proud of the package as a whole; it is centrist, it is substantial, and by virtue of the strong support each element elicited, it makes a strong statement that will greatly assist the Governor, the Legislature, and leaders of private organizations. Thank you very much.

And now, Mr. Chairman, with your indulgence, you -- the members will recall two meetings ago we heard an oral briefing by Dr. Helen Schauffler of University of California Berkeley, regarding the first two elements of the survey for the Task Force Commission.

You'll recall that at that time we were still in the field in the third sample of that survey. Dr. Schauffler is back today to give us a brief summary of the results of that third sample because of the Task Force's strong interest. I will note that you should have at your stations a copy of a survey brief produced by the -- which includes a brief summary of the third sample findings as well as the findings as well as the other two samples.

With that, Dr. Schauffler, if you'll take a couple of minutes, we'd love to hear from you.

DR. SCHAUFFLER: Thank you very much. I'd like to thank the Task Force and Dr. Enthoven for the opportunity to present the findings from this last sample. And what I'd like to do is just briefly review where we were when we left off with the first two samples, and then describe some of the major findings from the third sample which was people with chronic conditions that are known to benefit from medical treatment and/or people who had been hospitalized in the last year.

As you recall, and I think as everyone knows, there's been a tremendous amount of attention paid to satisfaction with health plan, particularly with the reporting of the survey findings, and I want to just make clear that the purpose of our survey was not really to conduct a satisfaction survey. I've been involved in doing satisfaction surveys with specific business groups on health --

THE REPORTER: Excuse me, can you talk a little bit slower. Thank you.

DR. SCHAUFFLER: Oh, I'm sorry. I tend to talk very rapidly.

Our survey really wanted to go beyond satisfaction and attempt to identify what kinds of problems people were experiencing with their health plan, and whether or not there were differences by

different types of managed care that might be associated with the economic incentive structural features of different kinds of managed care and to find out how serious these problems were, what kinds of impact they were having on consumers to help inform the deliberation of not only this Task Force, but hopefully the legislature over the next year or two.

This first slide shows that overall in California, as you all are aware, 76 percent say they are satisfied. And I think we should be pleased that most would view this as a passing grade. The system is not failing. 76 percent are satisfied, but about four million insured adults in California do not report that they are satisfied, and it's that group that I think we need to be particularly concerned about.

Working with PBGH, they establish for all the HMOs in California a minimum benchmark of 80 percent satisfaction. And if a health plan fails to meet that level of 80 percent satisfaction, PBGH considers them not to be performing acceptably. In fact, the plans have to refund part of the premium.

The target that PBGH has set for all of the HMOs in California in terms of satisfaction is 90 percent. And it's only when a health plan, like the health plan of the Redwoods meets a 90 percent greater target do they consider the plan to be performing at an acceptable level. So I think the message here is we're doing okay, but there's a lot of room for improvement.

The second slide shows differences across different types of managed care plans in terms of overall rate satisfaction, as well as the overall rates and problems. And what we see from this slide is that there's no question that the group model HMO has the highest rate of satisfaction, 83 percent exceeding that PBGH minimum performance standard, and that the rate of problems is clearly highest in the IPA network model HMO, and lowest in the group model HMO. So just from these very gross findings, I think we conclude that the group model HMO is doing a better job overall than the IPA model HMOs, and the PPOs fall somewhere in between.

Next slide. I won't take time to go over this, but I wanted you to have -- this is sort of my handy-dandy summary sheet of what the differences are by different types of managed care in California from our survey. I've indicated both the proportion of the adult population that's insured, also pointing out that 13 percent in our sample were either in traditional Medicare, 5 percent Medi-Cal, 4 percent private fee-for-service, 3 percent unless we weren't able to look at those groups individually. I also listed the primary problems that are specifically associated with each different kind of plan, and the consequences of those primary problems with their health plan.

And as you can see, for example, with PPO the major problems are with billing and claims and benefit coverage and not surprisingly the major impact

is a financial one. Whereas where we see with the HMOs, there are many problems that people are reporting with the ability to access care or their choice of providers. And what we see in the IPA is a financial impact as well as a health impact, and what we see in the group model is impact in terms of lost days of work and also a health impact.

Next slide. What I want to focus on briefly today is the experiences of adults with chronic conditions or who have been hospitalized in the last month. The sample which was the third sample out of the three surveys was a 1,227 adult insured Californians who have lived in our state for at least 12 months and/or who were hospitalized in the last 12 months or had one or more of the following health conditions.

I want to point out that these health conditions were helped selected with the help of Arnie Milstein at Mercer and with John Wier at the New England Medical Center who's doing the medical outcome study. And we specifically selected these chronic conditions because they are known to benefit from early and sustained medical treatment, and they include: Hypertension, heart disease, diabetes, cancer, asthma, migraine, chronic lung disease, HIV/AIDS, severe arthritis, heart attack in the last year, treated for depression in the last year, and given birth in the last year.

Next slide. I'm organizing the results

into three different sections. First, I want to present the differences by health status, and I've subdivided this sample into three different groups because we observed that in fact their experiences were quite different. The first was people with chronic conditions only who hadn't been hospitalized in the last year. The second group is those who were hospitalized in the last year, but have no chronic condition. And the third is the group who has both one of the chronic conditions and were hospitalized in the last year. Then I'll present some results by type of managed care and by type of chronic condition.

Next slide. As you can see from this slide, this looks at the relationship between the three subgroups, hospitalized only, chronic condition only, and chronic condition and hospitalized and their health status. And what becomes very, very apparent is that the rate at which people report excellent and very good health status compared to the general insured population is in fact higher for those who were hospitalized only and have no chronic condition was slightly lower for people who have a chronic condition but weren't hospitalized. But is substantially lower for people who had a chronic condition and who were hospitalized.

Similarly, if we look at the fair and poor health, we'll see that the rate at which those with both the chronic condition and were hospitalized for fair or poor health is more than double the rate for the

general insured population. So I think we can say pretty clearly that it's this group, chronic condition and hospitalized, that are really the sickest members of this sample.

MS. FARBER: Are we allowed to ask questions? Is that all right, Mr. Chairman?

CHAIRMAN ENTHOVEN: Yes.

MS. FARBER: I'd like to know if there is a significant breakdown with excellent and very good? You've lumped together --

DR. SCHAUFFLER: I did because the slide was so busy. The relationships were the same --

MS. FARBER: How many people rated their plans excellent as compared to very good?

DR. ROMERO: This is health status.

MS. FARBER: How many of them rated it that way?

DR. SCHAUFFLER: I can break it out for you. When I had five different groupings on the slide, it was too busy so I combined them.

MS. FARBER: But do you recall whether there was a significant breakdown between excellent and very good?

DR. SCHAUFFLER: Across these three groups?

MS. FARBER: Yes.

DR. SCHAUFFLER: Yes, there was.

MS. FARBER: There was.

DR. SCHAUFFLER: And similarly there was a difference between fair and poor as well.

MS. FARBER: So in fact, this doesn't really tell the whole story.

DR. SCHAUFFLER: No, no, what I'm saying is the differences we observed when we combined them are the same differences that we observed when we look at them separately.

MS. FARBER: I'm just really curious how many people thought under the care of the health plan that their health status was excellent?

DR. SCHAUFFLER: I'd be happy to provide you with those data. It was simply for visual purposes that I combined them. But I think you'll find that you'll draw this in conclusion. Okay. Thank you.

The next slide looks at the rates at which people report having any one of the 13 problems that we asked about or any other problem not included in our list of problems. And as we know, 42 percent of the general population responded yes they'd had one of those or more or some other problem. And where we see really no difference in terms of people who had chronic condition only at rate at which they report problems is 44 percent which is not statistically different from 42 percent.

Where we see the higher rates are people who had a chronic condition and were hospitalized or people who had been hospitalized only where we'd seen

more than half of them reporting that they've had a problem with their health plan in the last year.

DR. ROMERO: Helen, just clarify a question. Would you refresh our memory please. How -- was the question asked in such a way that it was simply about problems with the health insurance plan --

DR. SCHAUFFLER: Yes.

DR. ROMERO: -- or problems more generally?

DR. SCHAUFFLER: The question -- actually I think you all have copies of the questionnaire in front of you. The question asked them if they had experienced any of the following problems with their health plan in the last 12 months.

DR. ROMERO: And was explicitly with their health plan?

DR. SCHAUFFLER: Yes, everything was focussed on the health plan.

DR. ROMERO: Thank you.

DR. SPURLOCK: It looks like on this slide that the hospitalized only were the ones with greatest number of problems, and yet on the previous one the hospitalized only were also the highest health status.

DR. SCHAUFFLER: Right, and what you'll see in a minute is they have mostly billing and claims problems, and their problems are more likely to be resolved compared to other people.

Okay. This slide shows that where there were differences in the rates of problems across these different subgroups, these were the problems where we found differences. And as I just mentioned, as you'll see in billings and claims, the rate at which people who are hospitalized only experienced problems with billings and claims, so it's more than twice that as the general insured population, and that's where they really stand out in terms of the problem that has the greatest prevalence for them.

In terms of reporting that staff, doctors, nurses, administrative staff, other personnel were insensitive or not helpful to them, we see that the rate is almost double the general insured population for those who had chronic conditions and were hospitalized. Yes?

DR. SPURLOCK: Other than what you just pointed out, are there any independent predictors of these health status -- is health status an independent predictor of any of these other categories --

DR. SCHAUFFLER: I'm sorry. I'm not sure of what your question is.

DR. SPURLOCK: Did you do aggression analysis to find out if there are independent predictors of health status of any of the problems?

DR. SCHAUFFLER: Yes, we did for the general insured population, and they are. Health status -- in fact, I did a multiple aggression model on

predicting any problem, and the only two variables in the multivariate model that were statistically significant were IPA model HMO and health status. But I wasn't prepared to present those results today.

Okay. The -- in terms of being forced to change medication, we see that as being a significantly higher problem with people with chronic conditions only as well as those with chronic conditions and hospitalized. Transportation for people who had chronic conditions and were hospitalized and being denied care at about thrice the rate of the general insured population for the first two categories and about three times the rate for chronic condition and hospitalized.

Next slide. We didn't see much difference, however, actually in financial in the rate of which these different subgroups reported a financial loss related to their problem with their health plan the range is about 26 to 29 percent, both for the general insured population as well as for each of these subgroups. And the only group that where there seems to be a difference in terms of the amount of financial loss is among the chronic condition and hospitalized at a rate of about 14 percent, and 13 percent for chronic condition only.

Next slide please. In terms of lost time from work, we see for again for chronic condition and hospitalized people a rate of about 50 percent higher than the general insured population which is not

surprising. And then both for hospitalized only and chronic condition and hospitalized they report a much higher rate of losing more than one week of work. And again hospitalization is not surprising that in both those cases would result in more lost time from your job.

Okay. Next slide. This is the question where we asked people whether or not the primary problem they had with their health plan resulted in various health outcomes and I've only reported on three of them here. And I think what leaps out at me is that this group in group chronic condition and hospitalized clearly is reporting the most serious health impacts with the problems that they're having with their plan with that group reporting that their condition worsened as a result of their problem with their plan at a rate of 50 percent higher than the general population, that it led to a new condition that wasn't previously present at about two times the rate of the general insured population, and that it resulted in some kind of permanent disability affecting their activities of daily living at almost three times the rate of the general insured population. So these are very serious reports I think on the part of the population who falls into the subgroup which I think merits our close attention.

CHAIRMAN ENTHOVEN: Excuse me, Helen, do you think that people made a clear distinction in their minds between the health plans and the medical care they

got? I mean if somebody's in XYZ health plan and they're cared for at the Ross Valley Clinic, and they felt that their health care worsened, are you confident --

DR. SCHAUFFLER: Right. We didn't ask them who we thought was directly responsible, and I think that we all understand that a lot of these problems in terms of solving them requires solutions that may fall out of the boundaries of the health plan. But many people associate their health plan with their health care. We specifically asked about the health plan. We didn't ask about the clinic. So I honestly don't know what they were thinking. I know what we asked, and I know how they responded.

CHAIRMAN ENTHOVEN: That's an important ambiguity there because some people will interpret this to mean that somehow the health plan led to their condition being worsened. I presume it's the medical care, what the medical group did.

DR. SCHAUFFLER: Right, but they get their medical care through their health plan, so I think the distinction for the consumer is there isn't one.

CHAIRMAN ENTHOVEN: Well --

DR. SCHAUFFLER: And especially with an HMO, maybe it's not so much the case with a PPO, but the nature of an HMO is that you combine the medical care and the insurance function --

CHAIRMAN ENTHOVEN: What you're saying,

though, then is this is a distinction that is not meaningful. The difference between health plan and the actual medical care. I mean why didn't you say the primary problem with medical care people resulted in poor health status?

DR. SCHAUFFLER: Well, I'm not sure -- I don't know if the results would have come out any differently, Alain, I didn't ask that question, so I can't say. But my guess is if we did broke down the answers to those questions by health plan, we would probably find the same thing.

DR. ROMERO: Can I summarize, Helen? You're saying in essence that in your opinion most respondents don't make a distinction about which part of the health care system is responsible?

DR. SCHAUFFLER: That's correct.

DR. ROMERO: You asked about health plans --

DR. SCHAUFFLER: Correct.

DR. ROMERO: Some of them may have answered in those narrow terms, but most probably answered more generally; is that a reasonable inference?

MS. SKUBIK: The actual sequence of the questions is worded very carefully. It says, "In the past 12 months you said you had one of the following problems with your health insurance plan. Did your problem involve financial loss, and then did the problem cause you this and that?" It's about the plan, so the

wording is quite clear.

DR. SCHAUFFLER: And it's all tied to the primary problem they identify with their plan, so everything is continuously linked and using that same language.

CHAIRMAN ENTHOVEN: All right.

DR. SCHAUFFLER: Thank you. Okay.

Next slide please, Terry. Interestingly we also see that this group, the chronic condition and hospitalized, are much more likely to try to resolve their problem in the last year. I'm not quite sure what to make of this except perhaps maybe they perceive their problems as being more serious, but we do see that 65 percent compared to just 57 and 58 percent of other -- the general insured, and other people in this sample did attempt to resolve their plan last year.

Next slide please. Unfortunately the rates of which people's problems are resolved does not vary significantly at all. Depending upon which subgroup they fall in, but what we do see is this group of hospitalized only is the most likely to get their problem resolved to be -- I mean to be satisfied with the resolution of their problem with 63 percent, and this group with chronic conditions and hospitalization is the least likely to be satisfied with the resolution of their problem. So I think this is all somewhat consistent.

Next slide please. If we look at sort of

the overall rate, for example, for all of those who reported a primary problem to us, what percentage of those reported that it was resolved satisfactorily, what we find is really not too much difference, but that the rates at which the primary problem people were reporting were satisfactorily resolved or only about 15 to 19 percent which is quite low. I would hope particularly with the recommendations that the Task Force has in grievances that this would be improved.

In terms of differences by -- I wanted to look and see whether the rates or the proportion of the population that was in these different three subcategories varied by type of plan, and that might in fact explain differences by type of plan. So that a certain group, for example, the chronic condition and hospitalized were over-represented in IPA, that would explain the higher rate of problems in IPAs. But that is not the case as we say in group HMO, IPA network, and PPO this group chronic condition and hospitalized is slightly or even significantly under-represented in those plans, and where a substantial proportion 35 percent of that group is in Medicare, Medi-Cal, and private fee-for-service, so that we really only have about 65 percent of people who have this chronic condition and hospitalized status in managed care. And so that's the group I'll be talking about when I look at the breakdown just to be clear that they're not all in managed care.

Next slide. For this whole sample of chronic condition hospitalized, we basically see the same pattern that we saw with the general insured population but actually with higher rates of satisfaction overall. With this population of chronic conditions and hospitalized in the group HMO purporting 90 percent satisfaction which is PBGH's performance target, and probably not surprising about a health plan of that characteristic received their blue ribbon award for excellence. Whereas, we see with the IPA network model it's significantly lower with 77 percent reporting satisfaction similar to the general insured population with dissatisfaction in that type of plan model as high as 12 percent.

Next slide please. If we look at the rates at which people report any problem, again we see a similar pattern with only 39 percent in the group model, 53 in the IPA network, and 46 percent in the PPO.

Next slide please. Again, although the rates are a bit higher, we see that in terms of billings and claims and problems with benefits those are the most prevalent for this subgroup in the PPO model followed by the IPA which is the identical finding that we had for the general insured population.

Next slide. And again we see problems in terms of delays in care, referrals to specialists, and being forced to change doctors highest in the IPA network model HMO followed by the group HMO and delays

in care and referrals to specialists.

Next slide please. Finally, I just want to present just a few things. We did have a sufficient sample size to actually look at some chronic conditions which was a pleasant surprise. We certainly didn't have enough sample to look at all of them, but we were able to look at some of them. And in terms of benefits and billings where we observed significant differences from the general insured population where with asthma, migraine, and depression with clearly the highest rates of problems with benefits, being denied care, and billings and claims being among those with depression followed by those with migraine. And I think this confirms what we've been hearing from consumers about lack of coverage for mental health benefits and difficulty in accessing those services.

Next slide please. This slide looks at problems with care in services by chronic condition, and I'd just briefly like to go over each of them. The first set of bars is that they did not get appropriate care and we see the highest rates for people with diabetes, migraines, and depression. In terms of delays in getting care, we see significantly higher rates with people with asthma and with depression. And these are particularly concerning, I think, because asthma does require as does depression quick access to services to prevent poor outcomes.

In terms of insensitive staff, we see the

highest rate in migraines and depression. And in terms of problems with referral to specialists, those were the most difficult for people with asthma and people with migraines. The asthma findings particularly surprised me given the fact that the majority of the health plans do have asthma management health programs, so this is a signal that maybe we need to be doing something differently.

Next slide please. In terms of choice, what jumped out to us was that in terms of being forced to change medications for blood pressure, diabetes, migraine, depression, asthma, and heart disease, we have more than 10 percent and up to 15 percent with asthma and heart disease telling us that they were forced to change medications in the last year that that was a problem for them.

In terms of being forced to change doctors, we see that primarily with persons with migraines and depression. But I think it's being forced to change medication for nearly everyone of the chronic conditions that we examined again tends to validate the concerns that we've been hearing from consumers about generic drugs and formularies.

The next slide. We're almost done. This slide looks at the primary problem by chronic condition, and again I just want to point out a couple things under care and services. You can see the people with asthma have significantly higher rates of their primary problem

being with care and services. In terms of choice, and this is largely choice effected by choice of medications we see the highest rates of problems with people with blood pressure, heart disease, and diabetes. In terms of not covering benefits as a primary problem for people with migraines and heart disease and access which means both transportation and language of communication we see the highest rates being reported for people with blood pressure, diabetes and heart disease.

Next slide please. Finally, I did take a look given the concern that many have expressed about lengths of stay for maternity care. I did break out those who had been hospitalized for pregnancy compared to those who were hospitalized for other reasons and looked at the responses to question about whether they felt they were discharged too soon or the right time or stayed too long. And as we can see, for people who had a chronic condition and were hospitalized for the total hospitalized it's about 23 percent, and it's significantly higher for hospitalized for pregnancy at 32 percent again validating some of the anecdotal information we've been hearing about how consumers were feeling for the length of stay for pregnancy.

In conclusion, I would just like to say that this service data is a tremendously rich source of information, I think that hopefully can guide us. There's a lot more analysis that would like to be done, and I would love to speak with any of you about specific

questions that you would like answers to. I think it confirms much of the testimony that the Task Force heard regarding problems that consumers were experiencing with their health plans, and I think it also provides validation to support many of the Task Force recommendations including changing HMO oversight, the grievance process, capitating doctors, dropping providers, and referrals to specialists. Thank you very much.

CHAIRMAN ENTHOVEN: Thank you. Nancy?

MS. FARBER: I would like to know who owns this data. Since it was created for a public purpose, will there be public access to it?

CHAIRMAN ENTHOVEN: I presume so. You want to comment on that?

DR. SCHAUFFLER: Yes, there will be. At the moment I have first rights to publish from the data, and then I will be making arrangements to make it a public set through UC data on the Berkeley campus, which is open to anyone who wants the data available to them.

CHAIRMAN ENTHOVEN: Ron Williams?

MR. WILLIAMS: Yes, I have a question about the opening slide and the subhead part of the inferences at 76 percent of insured Californians are satisfied.

DR. SCHAUFFLER: That's what they told us.

MR. WILLIAMS: Right, but from that is it

accurate to say that 24 percent are dissatisfied?

DR. SCHAUFFLER: I didn't say that. I said 24 percent say they are not satisfied.

MR. WILLIAMS: Well, how many are dissatisfied?

DR. SCHAUFFLER: 10 percent, about 1.6 million people.

MR. WILLIAMS: So 10 percent are dissatisfied?

DR. SCHAUFFLER: Correct.

MR. WILLIAMS: And then 76 -- help me with how would you appropriately characterize this?

DR. SCHAUFFLER: There's another group of people that says they're neither dissatisfied or satisfied, so they're not satisfied, but they're not dissatisfied.

MR. WILLIAMS: I guess my question is really a question that really spins here in terms of clarity and communication. It seems like 10 percent of the consumers are dissatisfied or --

DR. SCHAUFFLER: That's correct.

MR. WILLIAMS: -- and that's a big number --

DR. SCHAUFFLER: That 24 percent are not satisfied.

MR. WILLIAMS: All right.

CHAIRMAN ENTHOVEN: Rebecca Bowne?

MS. BOWNE: Helen, you had a chart that

isn't in our packet that I wondered if at some point staff could somehow make it available to us. You mentioned it earlier. I think it was the second one.

DR. SCHAUFFLER: Oh, you should have it by itself. You don't have it?

MS. BOWNE: I don't think so. But in any event, it was a good chart along with the other information, so I wonder if staff could make that available to us.

DR. SCHAUFFLER: Maybe I forgot to pull it out of my briefcase, so I will check right after this.

DR. ROMERO: The chart question was the table.

DR. SCHAUFFLER: No, I Xeroxed that separately.

CHAIRMAN ENTHOVEN: Okay. Peter Lee?

MR. LEE: It's a couple quick comments rather than questions. First, there's been a lot of discussion about satisfaction rates, and I think one of the things Helen knows this primarily wasn't a satisfaction survey. It was primarily a survey that we wanted to provide a window on where the rough edges in managed care, where the points of friction, and I think that I very much appreciate the work that Helen's done, and it's similar to the work the Luewim Group did for the Health Rights Hotline in the Sacramento area. Again, not saying the only problems that we're here to

do, but the Task Force is to try to rub out some of those friction points. And this is identifying friction points.

The note about satisfaction rates, it really identifies a real dissidence with the high satisfaction rates and high rate of problems, many of which are significant in terms of as reported by consumers responding costing them a lot out of pocket, worsening health care. And I think we've done a good job in many of our recommendations helping to address some of those problems.

A couple other notes is there's been certain points raised about the balance of the survey. I was involved providing some input on the questions and survey design as were I know about ten other Task Force members including Ron, including Bill Hauck, including Maryann O'Sullivan, and there was a broad range of people involved that provided comments on the survey development. We had the survey reviewed by the Luewin Group because we're interested in the similarities and differences between the survey done here. And they reported to us, they see no reason to see anything in the nature of bias. In the survey, itself, we need to understand the differences in responses to one survey we did here, the survey throughout the state, but I think that we need to as a Task Force and really as a state look at this data, and the health plans need to look at the data to see what's this mean for asthmatics, what's

this mean for diabetics, and to my knowledge this survey is one of the first that does that. And it's pushing the envelope for us to understand where's the friction.

And I really want to appreciate Helen and the work I was able to do with the Task Force staff to create what I think really adds to all of our ability to address some of the problems that are clearly out there.

CHAIRMAN ENTHOVEN: Allan Zaremberg?

MR. ZAREMBERG: Helen, have you done crosstabs or are you going to so you can narrow it down where you identify the problem that you can identify it with the type of plan that is, and we have -- do you know --

DR. SCHAUFFLER: Yes, in fact, in that table that you seem to be missing that is broken down by type of plan.

MR. ZAREMBERG: And have you done that on all the things where you can cross reference in other words --

DR. SCHAUFFLER: In fact, the blue survey brief that you have, there are a number of tables that breakdown both the prevalence of problems as well as the primary problem by type of plan.

MR. LEE: Allan, many of those are in the Executive Summary or in the report Volume 1, the public perceptions results show by plan 1. So what will be Volume 1 of our report include many of those comparison by plan type, excluding the results from the chronic

conditions population as I understand it.

DR. SCHAUFFLER: We were able at the last minute to add just a little bit about the chronic condition sample.

MR. ZAREMBERG: And, for example, on the mental health coverage or the depression or the migraines, was, and I think you sort of broke it down here that lack of coverage, some people probably weren't satisfied with the level of coverage they had --

DR. SCHAUFFLER: Right, or they misunderstood the coverage --

MR. ZAREMBERG: They misunderstood the coverage because I think that's one of the places where there isn't coverage in many respects. And how much of a percentage, and I think this comes -- well, I don't know if it comes back to the question Ron asked, but does, you know, how many out of the 10 percent who are dissatisfied, I guess is the question, fall, you know, or cross referenced with these particular problems here? In other words, are these significant problems that you identified with asthma, with migraines, with depression, are those the people in the 10 percent category?

DR. SCHAUFFLER: Unfortunately, 10 percent of 1200 is 120, and then when I start breaking that down to chronic conditions I just simply don't have enough sample with any degree of accuracy to say a specific chronic condition in a type of health plan. The data just it's --

MS. SKUBIK: Since we've already invested in the development of this survey instrument, and so forth, if we wanted to as a public increase those sample sizes to delve into the kind of questions Allan Zaremberg is raising, that is something that we should consider on the research agenda.

CHAIRMAN ENTHOVEN: Maryann O'Sullivan?

MS. O'SULLIVAN: Dr. Enthoven, I wanted to ask something of you in this context. Your letter that follows the Task Force's findings and recommendations has a conclusory statement that says that the polling was biassed in your opinion. And your opinion carries great weight because you're the Chair of the Task Force and apparently were quite involved in developing the poll. I'd like to ask you to delete that statement, to leave your comments in there where you have concerns about how the media has spun the poll and other concerns you have, but to take out that statement. It's a single sentence. It's in italics, and it's very strongly worded, and I don't think it's fair.

CHAIRMAN ENTHOVEN: Well, Maryann, if I have an opportunity to do so, I'm happy to go back, reconsider, and think about it. I can't make any guarantees now. Let me just say to you and Peter, though, my main concern was that the existence of problems, which I can appreciate is very important from a political point of view for legislature that's a big problem, but from the point of view of evaluating the

health and medical care system is functioning you would need to have some evaluative information about you might say the merits of the issue. Let me give you an example.

I was very impressed by the doctor in Fresno who said the thing he didn't like about managed care was that it made his patient and him adversaries. You recall that? He said he had a pregnant patient who came in and said she wanted an ultrasound, and he said, "I find no medical indication for ordering an ultrasound for you at this time, and, therefore, I won't order it."

Now, it's an interesting question about what do you think about that? My first reaction was, "Thank you, Doctor. We have a terrible problem with health care costs in this country, and I am grateful to you for making this judgment, you know, balancing the evidence and everything, that this is not necessary." But if that patient had been questioned by Dr. Schauffler, the patient would have said, "I have a problem with a referral to the specialist" or something.

So I think my big concern is at least the way this is being read is the existence of a problem is being taken as some kind of indictment of the system. And I would say you really have to look at the merits of the complaint if you like. Especially on the question of specialists because recall many experts for many years have been saying the American people make much too much use of specialists, more ought to be done by

primary care physicians. I presume that that is what the state legislature had in mind when they were trying to force the University of California to increase the number of generalists and cutback on the number of specialists. That's been a widely held view.

Now, if you accept the validity of that view, then part of what managed care has to do is to convert people of the idea that you start with your primary care physician, and you don't always go directly to a specialist. So I would feel better informed by a survey that would actually look at bunch of those cases and consider the merits and have some expert evaluation. Say this person wanted a specialist or wanted the ultrasound, and there was no medical indication for it versus this person who should have had a referral and didn't get it. And I don't doubt that there are some people who are being denied referrals to specialists that they ought to have, you know. But that's my concern is that --

DR. SCHAUFFLER: But, Alain, I think the survey was not designed to make those distinctions. I think where we've identified that there are significant problems, I think it's worth exploring the validity of it, but I think the survey has tremendous value, and that people are experiencing these as problems, and that they're reporting in a sufficient number of cases that perception of a problem associated with the health plan is also having an adverse outcome on them. And I think

whether or not -- we can't make the distinction -- we don't know whether the case that you're talking about is 1 out of a hundred or whether it's 90 out of a hundred, and there's no way to determine that, but we do know that there's a hundred.

CHAIRMAN ENTHOVEN: That's my problem, and I think people ought to recognize that --

DR. SCHAUFFLER: But this doesn't mean it's biassed against managed care.

MS. O'SULLIVAN: I think it creates an important road map and tells everybody where they ought to begin looking, and your statement's just sort of blanket saying it's biassed points people in the wrong direction. It says don't look at this. It's not a useful document. Doctor, I hope now you'll agree to take it out, but if you don't want to I'm going to look to take a vote when we do the transmittal letter to put in a statement in that says the majority of the Task Force finds this a valuable tool.

CHAIRMAN ENTHOVEN: Well, I'm not going to agree to change the letter until I've had a chance to go back and read it and think about it.

MS. O'SULLIVAN: Then I'll look for the vote on the transmittal letter.

MS. SKUBIK: From a research standpoint, I'd like to follow up on this dialogue right now. Now what Dr. Enthoven is saying is that this survey as Peter said indicates some rough edges in managed care, in

health insurance, in medical care. This is what the California public is experiencing. So this is an early set of data. Now the question is from a policy standpoint what's the next step? Do we have the names, Helen? Can we go back to the field research organization to follow up with those people to do some medical chart review or if not in a next survey that we might do as a follow-up, perhaps through OSHBD (phonetic), not through this Task Force since this Task Force is disbanding. What is the research agenda that we can now determine based on this early data set?

CHAIRMAN ENTHOVEN: Okay. Dr. Spurlock?

DR. SPURLOCK: Brief comment. I'm kind of a glutton. I want it both ways. I want better referrals to specialists and medically appropriate referrals to specialists. I want both, so I think it's a way to find a way to do both. You make it medically necessary and meet the needs of the patients.

DR. SCHAUFFLER: I think that's all our fault.

CHAIRMAN ENTHOVEN: I'm sorry I didn't quite grasp the point. We want appropriate referrals and we don't want inappropriate referrals; right?

DR. SPURLOCK: I think the marketplace in businesses, and I know many health plans are responding to the way to develop new products and new mechanisms to fast track referrals, so that the referral problem is dealt with in a meaningful way. That doesn't mean you

do that for every patient on every time. I think when we talked earlier about the recommendation about a spectrum of chronic conditions and patients with mild asthma don't necessarily need to see a pulmonologist. We need to develop ways to meet their needs, to let them know that which involves education, which involves work at the primary care level, but does not necessarily involve a specialist. And, therefore, when you do that, you get both. You get the specialist, people who need to get access very rapidly, fast track, and you get people who don't in a more educated, more self-managed way.

CHAIRMAN ENTHOVEN: Peter Lee?

MR. LEE: Yeah. I very much appreciate your consideration of what you do with your letter which I think we all recognize is you can say absolutely whatever you want. I think what one of the things your comments help me is understand what you meant, which didn't come across, and to state in your letter that you're concerned that further investigation needs to occur about the respect of merits about problems and issues and who are the true, quote unquote, "actors," those two messages didn't come across. And what comes across is a more blanket indictment of the survey, and I didn't think it gave people a road map as sort of to use Hattie's term, but it's yours to --

CHAIRMAN ENTHOVEN: I'm happy to agree to go back and modify that to make it clear that -- perhaps

I should have said that it's the interpretation of the survey is in my view mistaken, if it assumes that each of these --

MR. LEE: Are meritorious.

CHAIRMAN ENTHOVEN: -- are meritorious. That's my concern.

MR. LEE: Sure. I read it. I was really surprised.

CHAIRMAN ENTHOVEN: Well, you know, I had to write it on horseback in a big hurry while answering calls from Task Force members, et cetera. And afterwards I felt I wish I had a few quiet days to think about it.

MR. RAMEY: Don't be too apologetic for your letter, Alain. Some of us support the letter very much and think it's right on the mark, and we haven't been heard from here in this little bit of exchange that we're having, but I personally think it's a fine letter, and if you wrote it on horseback, then it was pretty dam good.

MS. O'SULLIVAN: Dr. Enthoven, can I just --

CHAIRMAN ENTHOVEN: I can't even find my letter. I don't recall it being biassed.

DR. SCHAUFFLER: I would just like to say to the extent that we find negative things, they're likely to be associated with managed care since 85 percent of the insured population is in managed care, so

I guess I don't understand the comment.

MS. BOWNE: Next.

CHAIRMAN ENTHOVEN: Mr. Mark Hiepler?

MR. HIEPLER: Helen, I have a question because there's some debate here on who's dissatisfied, who doesn't care, and who falls in between. There's a lot of national statistics I've heard, and you probably know them as to encounter data. There's a lot of people who never even use their health plans. They don't know if it's good, bad, or indifferent, so that shouldn't be used a vote in support or a vote against.

Do you have any statistics based on our sample on how many are insured, but fortunately were never sick, so they didn't even have to go and therefore they were ambivalent?

DR. SCHAUFFLER: Who didn't go for a preventive checkup. We do, and I'd be happy to look at that for you. I didn't bring those data with me today.

MR. HIEPLER: Because I think the numbers, whatever you come up with, 85 percent, whatever it is, as I've heard some of the statistics there's 8 to 10 percent that don't even encounter or use their medical system. If you use that number there's 7 percent that are dissatisfied, and yet, you know, that's a real alarming statistic. It's not saying --

DR. SCHAUFFLER: Those people may be very healthy and satisfied, so who knows --

MR. HIEPLER: Exactly, and the whole

purpose for this Task Force, and if you've seen the movie "As Good As It Gets," and public perception is based in some reality, I think your survey shows reality. And to the degree, you know, people on the committee hoped that this would come up with just glowing, wonderful sonnets about managed care, I think that wouldn't have done its job, so I commend the survey for looking at the rough edges because unless we expose those, what can we improve?

CHAIRMAN ENTHOVEN: But I trust, Mark, to a degree we need some information about the merits of the complaints. The pregnant lady in Fresno, if she reports that she didn't get a referral, wouldn't you like to know that two or three independent doctors or panel of doctors look at it and say, "Well, she wanted it, but it wasn't needed." I mean do we want to let any doctors have any authority to decide against care that's in their judgment?

MR. HIEPLER: In a perfect world, that would be fine. But I think the survey with everybody's input, and many of the people who inputted weren't at all from my side of the circumstances at all. I think that you do as best you can, but it does point out some problems whether that's a meritorious problem or not, I would guess that most of them were meritorious.

DR. SCHAUFFLER: I would just like to add that my understanding was a lot of the problem in the health care cost was physician-induced demand what we

call rather than consumer-induced demand. That maybe changed under the old fee-for-service system, and reason that the UC office is being asked to produce more primary care doctors is because we have a terrible shortage of primary care doctors and oversupply of specialists rather than anything that has to do with referrals. Thank you.

CHAIRMAN ENTHOVEN: Tony Rodgers?

MR. RODGERS: As you look at the survey, and you look at the document that we have put forth as our recommendations, you say that we're pretty much on the mark. Was there any glaring gap that you see in what we have done that the survey would suggest we didn't address and that maybe we should make a statement on?

DR. SCHAUFFLER: Not that I'm aware of. I mean my understanding is that you recommended us standard benefit packet to deal with the benefits problems, that you recommended different oversight for HMO regulation which I think is needed. You dealt with the problem with problem of referrals to specialists, so the -- as far as I can tell, many of the most significant problems that we identified in the survey, the Task Force has addressed in the recommendations, and I'm delighted to see that, and I think the Task Force -- I would hope the Task Force would embrace the survey as justification for moving ahead on those recommendations.

MR. RODGERS: I think that's an important

point. As we look at the survey, what we commissioned the survey for. It was a target. We wanted to make sure our priorities were right. I hope the survey will be used by the legislature and the governor to look at of the recommendations, what I call the low-hanging fruit, the priority target areas, that the survey suggests we need to get on top of right away.

CHAIRMAN ENTHOVEN: Maryann, I will change the sentence. I will delete that sentence, and I will replace it with a sentence that says my concern is that the complaint or problems were not independently evaluated on their merits or something to that effect which is what my concern was.

MS. O'SULLIVAN: Thank you.

CHAIRMAN ENTHOVEN: Fine. I'm happy to do that. Our next -- thank you, Dr. Schauffler. Our next item of business is Consent Items.

Diane Griffiths?

MS. GRIFFITHS: When we received the materials concerning the public perception segment of the report, there was an appendix literature review finding --

MS. BOWNE: Excuse me, Diane, could you please speak up.

MS. GRIFFITHS: The mailing that we received on the public perceptions section had with it Appendix A on the literature review, and I wanted to know what the understanding was about where that would

be placed in the report. I don't recall any discussion about this being put in the main volume.

MS. SKUBIK: Volume 3.

DR. ROMERO: With the other appendices.

CHAIRMAN ENTHOVEN: All right. Next we'll proceed to the Consent Items. The order of business will be to adopt the Consent Items which consist of two documents, the November 21 and 25 business meeting minutes. The November 22 meeting minutes unfortunately are not available for adoption today. All of the nonadopted minutes will be included in the report appendices with the caveat that due to time constraints were not adopted by the Task Force.

MS. FINBERG: What happened to the 22nd minutes? Is there some reason they're not in here?

MS. SINGH: They were just not available. Staff had been working very diligently to prepare all the materials for the report, and the November 22nd meeting minutes were not able to be completed in time for adoption today along with the December 12th meeting minutes, the December 13th and today's meeting minutes which haven't even been drafted yet.

CHAIRMAN ENTHOVEN: So do I hear a motion for approval?

TASK FORCE MEMBERS: So moved.

DR. ARMSTEAD: Second.

CHAIRMAN ENTHOVEN: All in favor?

MR. KERR: I was present on the November

25th, did that show I was present?

CHAIRMAN ENTHOVEN: Rodney Armstead seconded. All in favor say --

MS. FARBER: Wait a minute. Is there going to be any discussion about the minutes?

MS. SINGH: It's a Consent Item and so generally we move and second. Do you want to take it off?

MS. FARBER: I would like to discuss the November 21st minutes, page 2, the third paragraph. "The government needs to consider recycling some of its savings achieved for Medi-Cal, selected contracting, and public health care." I believe we received expert testimony that morning that was very implausible type of recommendation, and the commentary we received was from Kim Belshe, and her commentary isn't included in the minutes to round out that discussion.

MS. SINGH: What page are you on?

MS. FARBER: I'm looking at the draft Executive Summary on November 21st --

MS. SINGH: Ms. Farber, we're dealing with the December minutes.

MS. FARBER: I apologize, but when we get there, can we --

MS. SINGH: So you don't have any corrections to the minutes at this point? You're referring to the Executive Summary; correct?

MS. FARBER: That's correct.

MS. SINGH: At this point in time, Members, we have a motion and second to adopt the Consent Items which are the November 21st minutes and the November 25th minutes. Those in favor of adopting the Consent Items, please say "aye."

TASK FORCE MEMBERS: Aye.

MS. SINGH: Those opposed?

(No audible response.)

MS. SINGH: The Consent Items have been adopted.

CHAIRMAN ENTHOVEN: Thank you. The next item is New Business. The first item in New Business is adoption of the Task Force's report -- the Executive Summary of the Task Force's report. I'd like to reiterate that the Executive Summary is a brief synopsis of the adopted findings and recommendations. The only admissible subject at this point is the faithfulness or accuracy of the Executive Summary; that is, this discussion is not an opportunity to reopen issues that have already been considered and decided, so the Executive Summary is now open for discussion.

Okay. Let's see. I just want to get the names here. We've got Farber, Perez -- so my point will be that we don't want to try to change the report now. We want to make sure that we agree that this is an accurate summary. I appreciate that when you summarize and make it briefer, then some things are going to get lost in the squeezing; that's inevitable. I hope that

we don't make so many additions that we recreate the full report in the Executive Summary. All right. Start with Nancy Farber.

MS. FARBER: I'm going back to the point I was making when I was in the wrong part of the agenda. I apologize. I want to go back to that discussion where we had this naive idea that somehow we were going to make up the safety net out of savings the Medi-Cal program was going to achieve by going through a managed care approach. And I think at that time we had a very thoughtful discussion of how naive that idea was by Kim Belshe. I think that concluding this in the face of having heard that testimony would make this a very ridiculous thing to assert. And I would recommend that rather than have us all look that naive about this problem, that we do something about it.

MR. LEE: Can I do a procedural proposal?

CHAIRMAN ENTHOVEN: Yes.

MR. LEE: I think it would be helpful, we need to cite where we are, and could I suggest that similar to when we are going through recommendations is that we deal with the first two pages only first, so people have comments about the findings and recommendations portion of the Executive Summary, we hold those until we deal with the first two.

MS. FARBER: I had two items that I wanted to discuss with this paper, and I don't know if you care to deal with this one first and then move on to

my second comment or how you want to handle this?

CHAIRMAN ENTHOVEN: I think I'd like to accept Peter's suggestion that we go page-by-page.

MS. FARBER: I'm on page 2.

CHAIRMAN ENTHOVEN: Let's first of all --

DR. ARMSTEAD: Could we go ahead and try to put the timing piece on this because if we're taking this page-by-page it could end up being problematic from the time perspective.

DR. ROMERO: Half an hour, 45 minutes?

CHAIRMAN ENTHOVEN: Okay. 45 minutes. Barbara Decker? Page 1.

MR. LEE: We're going to go paragraph-by-paragraph, Alain?

CHAIRMAN ENTHOVEN: Well, it's anything on page 1. Let's do it by page. So page 1, second paragraph.

MR. KERR: I was just going to suggest that managed care is a set of techniques it's going to coordinate patient care among providers, it doesn't --

CHAIRMAN ENTHOVEN: Without objection coordinate patient care.

MR. LEE: I'm going to pass around some -- editing by group is clearly a huge problem, and I tried to draft a couple of suggestions so people could respond and say, "Oh, my God, Peter, what have you done?" But see it in writing rather than speaking it very quickly.

The first is in that paragraph which I think we need to set up an introduction that we aren't just talking about HMOs, and I suggest a wording for that paragraph to frame from the very beginning what we mean by managed care is a whole range of delivery systems, and coming around in front of you is a substitute proposed paragraph for paragraph 2. Should I read it slowly so people who haven't got it yet?

MR. WILLIAMS: I have a procedural suggestion here because I'm beginning to think we're going to be here forever. My suggestion is that we have a set of findings and recommendations that have been done, appointed, and voted on by the group, and some of us, at least everyone in the committee has been through that process.

Trying to summarize is an inherently difficult process. What I'd like to suggest is some opening statement that has something to the effect, "In the effort to be succinct, some unintended changes in their meaning may have occurred. As such, any interpretation the Task Force finds in recommendation should be made, not from the summary, but rather from the source of the materials included in the body of the report." So instead of trying to rewordsmith the Executive Summary ad infinitum, that we just simply say, "See the full recommendation as approved by the Task Force."

MR. LEE: Ron, I think that's a friendly

amendment to my amendment with the exception that note really goes when you get to findings and recommendations. So after Roman Numeral II to have an introduction like that is appropriate. We've never discussed any of the introductory remarks that come before the final recommendations, so this is the first time we as a group have had an opportunity to talk about, for instance, what are the implications of cost, how are we addressing or not addressing the uninsured? So I think that's a great suggestion to add in language that an Executive Summary is just that. These first two pages, this is the only place they exist, so I don't know that that recommendation works for how we address the first two pages.

MR. PEREZ: Mr. Chairman, might I make another suggestion?

CHAIRMAN ENTHOVEN: Yes.

MR. PEREZ: Because what Peter is getting at is debating some of the substance of what's in this summary, and I think that's appropriate thing to do. I'm a little concerned with our time, and I think there's one step we ought to take, and that's taking care of grammatical, spelling mistakes, things like that, so that we if we don't change paragraphs, at least we're not presenting a document that we're going to be a little embarrassed about. So if we could first --

MS. SINGER: John, we've gone through that and made a lot of the grammatical changes.

CHAIRMAN ENTHOVEN: We're working on that.

MR. PEREZ: As long as we're sure that's taken care of.

CHAIRMAN ENTHOVEN: I trust we agree things like "members was sensitive," we're allowed to make it "members were sensitive." Some of those come when the phone rings and you're typing.

All right. So what we're honing in on here, we'll work on the first two pages, and then after that we'll make Ron Williams's statement. Did you write your -- I think that would be very helpful. We need something like that. Okay.

Ms. Farber?

MS. FARBER: This request for acknowledging the testimony of Kim Belshe so that this Task Force doesn't present the legislature and the governor with a paper that is naive, how are you going to deal with that? I mean it's ridiculous to think that you're going to --

CHAIRMAN ENTHOVEN: Nancy, when we get there, we'll look at the issue.

MS. FARBER: I thought we were looking at page 1 and 2.

MR. LEE: It's paragraph 3 of page 2.

MS. FARBER: We are there, so I guess I want to discuss it.

CHAIRMAN ENTHOVEN: All right. Let's go

back to page 1. We're on the second paragraph, and Peter has suggested an alternative definition of "managed care."

DR. SPURLOCK: Alain?

CHAIRMAN ENTHOVEN: Yes, Dr. Bruce Spurlock.

DR. SPURLOCK: I actually like what Peter wrote here in his language, and I think we can just substitute the entire paragraph for the entire second paragraph. One of things we've learned that debating the spin on counterbalance arguments don't go well with this group, so I think just a complete substitution of paragraphs would meet a lot of my needs.

CHAIRMAN ENTHOVEN: We'll just do straw votes. All in favor of Peter's proposal here. Okay. Very good.

MS. O'SULLIVAN: That was with Bruce's amendment?

MR. LEE: It's a swap of paragraphs.

CHAIRMAN ENTHOVEN: Now we'll go on to paragraph 3. Well, there is a little typo here. "Descriptive" and "Prescriptive" is that all right? The bottom paragraph page 1.

MR. LEE: Proposed insertion language which is I just want to make it clear that we are dealing with Knox-Keene and so my amendment picks up after Knox-Keene regulated health care service plan, it substitutes for them saying the full range of managed

care plan whether or not regulated under Knox-Keene Act affects quality of costs and how these entities can best be regulated. The intent is just to make it clear we are not a Knox-Keene advisory body.

CHAIRMAN ENTHOVEN: Okay. Can I adopt that without objection?

TASK FORCE MEMBERS: Yes.

CHAIRMAN ENTHOVEN: Thank you, Peter.

MR. LEE: Pleasure.

CHAIRMAN ENTHOVEN: Okay. Paragraph -- page 2, first paragraph. All right. The second paragraph, yes, Jeannie Finberg?

MS. FINBERG: Yes, I had a comment on paragraph 2 and this is something that comes up several times. I think it's in different letters and in the appendix where it describes the composition of the Task Force and equal numbers of health plan enrollees, consumer advocates, I think that's supposed to be consumer groups providers, health plan representatives and purchases. I think that's actually employers in the statute, and I'd like to suggest that somewhere maybe it would be here or maybe it would be attached as an appendix at the end that our list of members identifies that affiliation, so we know who is representing the consumer group, who is representing the employer, health plan, et cetera. We have a list in the appendix, but it just identifies the legislative appointees, and I think we need a more complete identification.

MS. SINGH: Ms. Finberg, we do that information with regard to the gubernatorial appointees; however, legislative appointees we have not received that information from the Senate Rules Committee or the Assembly Speaker, so staff have not received that information. We'd like to request that of the legislative appointees to secure that information so that we can accurately reflect which category they represent. I don't want to say -- I don't want it to be on staff's shoulders just to assume this particular person represents consumer; therefore, the --

MS. FINBERG: I agree it has to be official. But assuming we can secure that information --

DR. ROMERO: That's a big assumption, Jeanne, I made the request many times to no avail.

MS. FINBERG: Well, I really believe that we owe that to the public. We have been referring to this issue a number of times, and it's very confusing. I get asked that question all the times, and I've been serving on this Task Force since April, and I can't figure it out myself, and so I think --

MS. SINGH: I think that's a logical request, Ms. Finberg, and we have supplied the information as I mentioned on the gubernatorial --

MS. FINBERG: It is not on this chart --

MS. SINGH: We can include that in the appendix.

MS. FINBERG: And the other thing that is listed is the gubernatorial appointees, you can figure out by deduction the ones that don't have astrisks on them were appointed by the governor on them, but I think to have a balanced presentation that we should have a footnote by each one so we can have 1, 2 or 3 or one with the astrisks.

CHAIRMAN ENTHOVEN: Fine, without objection --

MS. O'SULLIVAN: I have a question about --

CHAIRMAN ENTHOVEN: Without objection we will include here the categories these people represent certainly for the gubernatorial appointees that we have, and if it is made available from the legislative appointees, that will be put in also.

MS. O'SULLIVAN: Will that also include, say, what organization people represent, what their affiliation is, and then have there on the Task Force --

MS. SINGH: We can also do that. Again, Members, we would request that if you've had any change in your job titles, or what have you, since your appointment that you submit that information to me via fax as soon as possible so we can accurately reflect your positions.

MS. FINBERG: Thank you.

MS. GRIFFITHS: I note there's an inaccuracy, one of the speakers appointees is not

designated Dr. Berkeley.

CHAIRMAN ENTHOVEN: That's paragraph 2. Now we'll take a look at paragraph 3.

MR. LEE: My proposed number 3 proposal really picks up at the end of paragraph 2 and going into paragraph 3. In the paragraph 2 it says, "For example," it talks about the uninsured. Then the whole next paragraph talks about the uninsured by the problem of cost shifting which we actually make a recommendation which I think the Task Force wanted to do to recommend broadly that looking at coverage of the uninsured is something that the state needs to do.

And my rewording just to make that recommendation stand out a bit more, and it's saying not a "for example," but it's really noting in particular the issue of the uninsured we thought as a Task Force is one that merits more attention, and it pulls that out a bit. It is in this area that I know that Nancy's comment comes up is how much elbow room is there for recycling as the discussion point, but I left it in because it was basically doing some shifting around of the language here.

CHAIRMAN ENTHOVEN: Could we all have a moment to read -- so what you're proposing here Peter --

MR. LEE: To substitute where it starts out "for example, the Task Force" through the end of the third paragraph.

CHAIRMAN ENTHOVEN: Okay. Fine. Let us

read it then.

MS. BELSHE: Mr. Chairman, maybe a question of clarification of Peter -- a recitation a recommendation made in the vulnerable population document Peter or where?

MR. LEE: No, it's not there. In many of our discussions broadly we've said the uninsured is not an issue brought before us.

MS. BELSHE: I appreciate that. I guess my question was in terms of the characterization of the consensual report of the Task Force that government needs to consider recycling some of the savings, et cetera. It's in the Executive Summary, the point that Nancy was making.

MR. LEE: Right. My point, what I thought the following recommendation, I just restated what followed in the Executive Summary is --

MS. FARBER: I think it is a fundamental error to assume that there are savings in the Medi-Cal program by redirecting its beneficiaries into managed care that are somehow going to function as a safety net. You know, that's ridiculous.

MS. BELSHE: I think more fundamentally, this is the very conversation this Task Force had last month, and the draft vulnerable population documents did include a recommendation to do just that. This Task Force was unable to reach a consensus on that recommendation, and it was not included there in the

vulnerable population document, and for that reason alone frankly I would strongly encourage that that reference be taken out whether it be in the draft Executive Summary or Peter's amendment.

MR. LEE: I'm very happy to pull that out in terms of encourage the state to consider just how to help safe net providers and develop individual approaches and delete the middle part which is the recycling part.

MS. BELSHE: I frankly think this is getting into a number of issues, whether it be the Executive Summary or the amendment that Peter has offered. The Task Force really didn't spend much time talking about in terms what are the implications of managed care for the uninsured, what are the implications of managed care for the safety net.

There was a validation of this group that the uninsured is a problem that you collectively are very concerned about, but you also appreciated it was outside of the purview of your charge. And it strikes me that that statement captures what you all talked about as opposed to getting into some of the more specific issues suggested both in the Executive Summary as well as Peter's amendment.

MS. O'SULLIVAN: My guess is we might have a majority to say that the Task Force thinks it is something important the legislature addressed if we delete the language to use Medi-Cal savings to do that.

CHAIRMAN ENTHOVEN: Peter, would you say then your modified recommendation, would we replace the end of paragraph 2 and all of paragraph 3 with your recommendation which just stops after Californians at the bottom?

MR. LEE: Yeah, and delete from specifically on. I would find that friendly. I also am concerned about the reimbursement rate in Medi-Cal and the implications that there may be more need to attend to the reimbursement rate rather than recycling, but I actually agree with it. I think it's a recommendation that we want to keep this issue before the legislature to address.

CHAIRMAN ENTHOVEN: Okay. Without objection -- Ron?

MR. WILLIAMS: Yeah, I guess the issue that I have a little bit of trouble with is that we're expressing, I think, appropriate concern about number of people who are uninsured, and I think that is a big problem. At the same time, we recognize we didn't have adequate time to consider the cost implications of our recommendations and the degree to which some of our recommendations will dramatically increase the costs. We talked about one last time that would have resulted in a ten million dollars increase in cost without dealing with the benefit.

So I guess the particular suggestion that I would make, Peter, is that at the end of your first

sentence, the end with growing numbers of uninsured in California, that we say something like or have adequate time to consider the cost implications of its recommendations on the number of uninsured. So we didn't have a mandate to engage in deliberations, nor did we have adequate time to consider the cost implications of the recommendations.

MR. LEE: Ron, you're foreshadowing my next paragraph which there is a whole paragraph in this Executive Summary on the cost implications of our recommendation. And I agree we need to address that issue. I don't think that's the place for it. I think -- so I agree we need to talk about costs of our recommendations. I think that I disagree with the first crack at it, but that's a separate issue I think. The issue of the uninsured clearly has costs and service implications which is a stand alone issue at this point.

MR. WILLIAMS: It just seems to me that they are tied together, that helping keep health care affordable is something that results in more people being insured. It permits a small employer to offer insurance. It encourages individuals to be in a position to buy insurance. So I think any statement about our concern in a number of uninsured has to lean back to helping to keep health care affordable.

CHAIRMAN ENTHOVEN: Ron, would you put a statement to that effect in that paragraph?

MR. WILLIAMS: Yeah, what I would have

done at the end of his third line which says, "growing numbers of uninsured in California," I would make that a comment say or have adequate time to consider the cost implications on its recommendations on the number of uninsured, period.

MS. O'SULLIVAN: I think we can address that in the next paragraph, and I'll vote against that.

MR. WILLIAMS: Thank you. I appreciate knowing that.

MR. PEREZ: Point of order, do we have a motion before us?

MR. LEE: We don't want to get bogged too much. If we did have a motion, I wouldn't consider that a friendly amendment. I think we had a separate discussion on the implications of cost including I do mention the uninsured. So that's why it's mixing issues it appears to me.

CHAIRMAN ENTHOVEN: Tony Rodgers?

MR. RODGERS: I just wanted to clarify something in assisting to write this particular paragraph. This was focussed on the safety net, and the implications that managed care has on the safety net that has relied upon fee-for-service, Medi-Cal, et cetera. This was not just about the uninsured, although the uninsured issue is what they're exposed to. I do agree there should be a paragraph that addresses affordable health insurance for the uninsured. But if you mix those two concepts together, I think you will

dilute what the focus of what this paragraph was all about.

CHAIRMAN ENTHOVEN: Okay. All right. Peter, I think we have this kind of a stylistic matter. We sort of have a duplication if we say the Task Force makes a recommendation and then the governor, legislature, private sector groups are strongly encouraged. I suggest we take out "makes the recommendation," and just pick up right away with "the governor, legislature, private sector groups --

THE REPORTER: If you're going to read off of that, could you read a little slower.

CHAIRMAN ENTHOVEN: Yeah. It's the last line before the --

MR. LEE: Yeah.

CHAIRMAN ENTHOVEN: Just to delete that.

MR. LEE: That's the last sentence of the paragraph.

CHAIRMAN ENTHOVEN: Now then we go on to --

MS. SINGH: Is there any objection?

MS. FINBERG: Can you tell me again? I'm not sure I follow. Are you going on Peter's draft or on your draft?

CHAIRMAN ENTHOVEN: Let me try to walk you through it. On the second paragraph at the end where it starts out "For example," as Peter proposes we --

MR. LEE: New paragraph.

CHAIRMAN ENTHOVEN: We make a new paragraph and then we pick up Peter's words, and we're going to delete from "for example" down to the end of paragraph 3, replace it with Peter's proposal, modified in the following two ways: First at the end of Peter's first full paragraph we delete "the Task Force makes the following recommendation," and we just pick up with the next sentence "the governor, legislature, and private sector groups are strongly encouraged to continue to seek to address the issue of large number of insured Californians," and we stop there. That is, we delete the rest of that.

MS. SINGER: Alain, could I make a suggestion? I'm appreciating Tony's comment and wanted to suggest that if you broke this recommended paragraph into two paragraphs, the second paragraph starting with "as state, federal, and private purchasers" instead of moving the current bullet point into the bottom of this paragraph, you make it the last sentence in the bottom of the first of those two paragraphs, and then you have -- you make a distinction between the problem of the uninsured and the problem of the safety net.

MR. LEE: I think that's great.

MS. SINGH: Is there any objection to that formatting change?

CHAIRMAN ENTHOVEN: All right. Without objection? All right. Thank you. Then we'll move on

page 2. Are we working on our summary or Peter's? Let's see now we're down to paragraph --

MR. LEE: I would suggest the substitution for the next paragraph.

MS. BOWNE: You know, Peter, at some point in this particular one really gets into the cost issue, and I'm concerned about the connotation of this suggestion in that I think that there were, if I'm not mistaken, 15 people which is not a majority, but our 15 people who were concerned about the fact that we did not take the time to cost out, and, therefore, the point that Ron Williams is making does come into play here which is if you add costs, you add to the uninsured.

DR. ROMERO: That's reflected in the second sentence of Peter's language, Rebecca.

MR. LEE: I think what Rebecca is talking about is my paragraph, page 2, paragraph 5, substitution. I'm happy to have language the Task Force members were sensitive to add in language in particular, you know, some Task Force or many Task Force members were concerned that if recommendations are too costly, that could increase the number of uninsured. I tried actually to be balanced, believe it or not.

MR. WILLIAMS: I guess the question is what's difference between your paragraph and what we have? Why are we changing?

MR. LEE: There's a couple of things. Where we came from at least 3 different iterations or

two different iterations about how we talked about cost. One is here. One is in Alain's cover letter which is somewhat different wording, some identical and some different wording.

What I tried to pull, I thought, the strengths from all of them, number 1, which is the note that we want to minimize costs. We did think about costs, but I think it's not a fair reflection to say we as a Task Force did not consider costs. We didn't do studies on them. Many things got voted down because of the express concern of high costs. We also made many recommendations for panels because we didn't have time to fully consider issues. I think that needs to be reflected, part of the rationale for those panels is we didn't have time to cost issues out.

Finally, what's different here from what's in the proposed is that we specifically propose not holding things entirely precost studies for implementation. This Task Force has never talked about that. Some of our recommendations are ready to go right out of the gate. Others need studies, and what I tried to reflect in the language is cost is an issue that should always be considered. But we aren't saying as a matter of course don't do anything, of all these recommendations some of which are urgent, some of which are tomorrow, some of which need further investigation. And so those are the various themes that I try to reflect in here.

CHAIRMAN ENTHOVEN: Could we just have a few minutes to read this uninterrupted.

Ron, what do you think?

MR. WILLIAMS: Well, I think that there is a couple of subtle differences that I sense. Peter, in your first line, there's an implication that we did not have time or resources to fully investigate all. We didn't have time or resources to fully investigate virtually any of the ramifications of what we're proposing. So it seems to me there is a soft peddling of the physical reality that we had to make very difficult judgments about what we thought would help make the managed care system work in California better. And we did the best we could. We listened to a lot of testimony, and we voted on recommendations that many of us feel will help things work, but we really didn't consider cost. And not for any and for virtually I think that is a very important distinction that I would make. And I think this soft peddles that issue as posed. I think the original language says in plain English we didn't look at it. We didn't have time. That's a limitation, so that's issue number 1.

I'm not sure how the panel process works, that's one I need to process a little bit more. But final distinction is there's a distinction that you're drawing about looking at costs on an ongoing basis and weighing the benefits. And I think there's a very again direct statement that says the cost of the Task Force's

recommendations should be evaluated and weighed against their benefits before being implemented. It seems to me that the original language is accurate. It's clear. It's a lot less which has certain benefits to me. And I just find this to soft peddle a couple of very key points.

MS. SINGH: Actually, Members, I'd like to suggest to the Chairman that at this point in time we take a straw poll vote on deleting the original paragraph and including Mr. Lee's substitution. There are 30 Task Force members present; is that correct Ms. Kauss?

MS. KAUSS: 29.

MS. SINGH: So we would need to have 15 even though we're not doing --

MR. LEE: What are we voting for?

MS. SINGH: We're voting for the deletion of paragraph 5 as you proposed, Mr. Lee, and substituting it with your language at this point in time. Those in favor, please raise your right hand. I'm going to count. Please keep your right hand up.

MS. SKUBIK: If you want Peter's language raise your hand.

MS. SINGH: We have 11 votes on the straw poll votes, so we will continue to include the original language as proposed.

MR. PEREZ: Can we take a straw poll on the current language too because the fact that we only

have 11 on Peter's language doesn't necessarily mean that we have 19 on the other language.

MS. SINGH: That's correct. I mean, but you can certainly do that, Mr. Perez, but what that would mean -- I mean, I would think at that point in time someone could make a motion to amend this paragraph. Is it the desire of this body to do another straw poll vote to determine whether or not to keep the original language?

MR. SHAPIRO: Could we have a discussion on the language?

CHAIRMAN ENTHOVEN: I think it would be appropriate to have -- let's agree which is going to be point of departure.

MR. LEE: Original language is point of departure.

MR. SHAPIRO: I actually feel the same Senator Rosenthal mentioned. There will be some consideration of cost by the legislature, and I actually have objection to singling out information as a cost producing long-term benefit and discriminating against other recommendations.

One thing that was in the Chairman's letter that was included in Peter's remark was using the reference "long-term" because this is going to be a charged issue in the legislature. We have statement by 14 members, not 15, indicating that they want to make sure that cost is looked at before anything is enacted.

I think there are a couple of issues there. In the Chairman's letter, he singled out information, something that's going to have long-term benefits and help the market. I think that long-term issue is legitimate across the board because all these things have short-term costs and the benefits tend to lag, so this is going to be a highly volatile benefit.

Kaiser Family Foundation has indicated to Senator Rosenthal this morning that they're going to look at the major Task Force recommendations provided the legislature and governor in the short-term in the next few months with preliminary numbers on these major issues. They've already looked at some of the issues previously, so we think we can have credible objectives.

I am a little bit concerned about the records too before being implemented because of the anticipated complaints we're going to have by many people saying you really haven't done an adequate job, like the survey, there are a lot of iterations on cost benefit analyses. I like Peter's reference too. You consider that issue as you look at these recommendations, but I can see people saying you haven't done enough and that issue hasn't be been fully weighed and evaluated. I think legislature will consider the recommendation of the Task Force. You should also consider the cost benefits of those recommendations, and I think that's the long-term costs and benefits.

And with that, I would argue again

singling out information as a state of cost --

MS. SINGH: At this point, Members, with the Chairman's indulgence, I would like to request that if you have any proposed changes to the original language that you simply propose your language. We need to move on. We have a lot of things to do.

Mr. Perez, I know that you wanted a straw poll vote, but I think at this point in time I think the best way to do is if you have any suggested changes, be it to completely substitute this paragraph, that you propose that.

CHAIRMAN ENTHOVEN: John?

MR. PEREZ: Move to delete the final sentence the cost for the Task Force recommendations should be evaluated and weighed against their benefits before being implemented.

MS. SINGH: Because this is a straw poll vote, we don't require a second, so those in favor of deleting that last sentence, again, I was corrected there are 30 Task Force members, so simple majority would be 16. Therefore, those in favor of deleting that last sentence, raise your right hand.

You have ten votes, so that sentence will stay in.

CHAIRMAN ENTHOVEN: Down to the last paragraph on page 2.

MS. O'SULLIVAN: Don't we have the opportunity to amend this paragraph? Did we vote to

keep this paragraph as it is?

MS. SINGH: Ms. O'Sullivan, you can suggest another change as I mentioned previously.

MS. O'SULLIVAN: I have three suggested amendments. The first one is the fourth line down, it says, "making cost increasing recommendations" making unnecessary cost increasing recommendations.

MS. SINGH: Ms. O'Sullivan, let's just take this one at a time. That's your first one? Okay. Members, those in favor of adding after making unnecessary cost increase.

MR. LEE: Just ask for objections to that. That's the sort of --

MS. SINGH: Does anyone have an objection?

MR. WILLIAMS: Yes, I have an objection.

MS. SINGH: There is an objection. All right. Then we'll take a straw poll vote. Those in favor of adding "unnecessary" to this paragraph, please raise your hand. You have 12 votes.

MS. O'SULLIVAN: Okay. I want to propose in that same line putting a period after recommendations and deleting the rest of that sentence.

MS. SINGH: Is there any objection?

CHAIRMAN ENTHOVEN: I object to that.

MS. SINGH: Okay. Members, those in favor of deleting "as premium increases would be likely to increase the ranks of the uninsured" please raise

your right hand if you support that deletion. In the same paragraph in the third sentence where it begins "making cost increase recommendations" Ms. O'Sullivan proposes to end the sentence after recommendations and to delete "as premium increases would be likely to increase the ranks of the uninsured." Okay. Those in favor please raise your right hand. You have 3.

MR. SHAPIRO: Alice, I'd like you to make a recommendation amendment based on my earlier statement. I didn't know you were soliciting at that point amendments. My proposal is to modify the last line and simply say "the long-term costs and benefits of the Task Force recommendations should be considered before they are implemented."

CHAIRMAN ENTHOVEN: What's the difference other than long-term?

MR. SHAPIRO: "Considered."

CHAIRMAN ENTHOVEN: As opposed to "evaluated and weighed"?

MR. SHAPIRO: Yes, because I worry about the adequacy arguments with regard to the Kaiser Family Foundation number. I think "considered" gives us flexibility to look at that issue without the challenge on the adequacy of evaluating.

MS. BOWNE: Michael, could I suggest that you divide that you will get support, at least my support, for the long-term costs, but not --

MR. SHAPIRO: Can we take the whole in

its entirety first?

MS. SINGH: Okay. Is everybody clear on Mr. Shapiro's proposed amendment? Okay. Mr. Shapiro, could you reiterate that again please.

MR. SHAPIRO: The last line would be the long-term costs and benefits of the Task Force recommendations should be considered before being implemented.

MS. SINGH: Then you would delete the sentences previously in existence?

MR. SHAPIRO: Yes.

MS. SINGH: Are all members clear? Those members in favor of substituting the language with Mr. Shapiro's language, please raise your right hand. I see 14. You still don't have 16; therefore, the language will --

MS. FINBERG: Okay. I have a suggestion that we delete the words before being implemented, so you leave the whole paragraph intact except for the last three words.

MS. SINGH: Is everybody clear on Ms. Finberg's proposal?

MS. FINBERG: We keep the paragraph as is, and we just end it before the last three words, so that the last sentence reads the cost of the Task Force recommendations should be evaluated and weighed against their benefits, period, so that we delete before being implemented.

MS. SINGH: All right. Members, those in favor of ending the sentence after "their benefits," please raise your right hand. You have 11 votes. The existing language stands.

MR. SHAPIRO: Could I ask a question and that is to indicate the long-term cost and benefits of the Task Force should be evaluated and weighed before being implemented? Is that --

CHAIRMAN ENTHOVEN: Michael, I think this is getting to be quibbling.

MS. BOWNE: I would agree with him on that. What I think Michael is getting at is there are both short-term and long-term and sometimes in order to get the benefits you have to look at the longer picture, so as conservative as I am, I find myself in agreement for the first time with Mr. Shapiro.

MS. SINGH: All right. Members, Members. Okay. Is it going to be the long-term and the short-term?

MR. SHAPIRO: I propose the long-term.

MS. SINGH: Members, the sentence would read "the long-term costs and benefits of the Task Force recommendation should be evaluated and weighed against their benefits before being implemented." Those in support of Mr. Shapiro's language, please raise your right hand.

MS. SINGER: Alice, before you read that into the record, I think you repeated "benefits."

CHAIRMAN ENTHOVEN: It would be "the long-term costs and benefits of the Task Force recommendations should be evaluated and weighed before being implemented." That's Michael's new language.

MS. SINGH: I stand corrected. Those in favor, please raise your right hand. You have 19 votes therefore we can accept that.

THE REPORTER: I need a break to change my paper.

MS. SINGH: We may have a one-minute break please or two-minute break.

CHAIRMAN ENTHOVEN: Maybe it's time for the Task Force to have a 7th inning stretch here. Have a short break.

(Break taken.)

CHAIRMAN ENTHOVEN: Will the members please take their seats. Now we've reached the first full paragraph, and it's 3 o'clock. We've got a lot of other important questions to do here, so I hope we can move quickly. In fact I'm hoping that Ron Williams's wording here will save us from such a review of all of the rest of the summary.

All right. We have the first full paragraph at the top of page 3, and Peter Lee has suggested a substitute paragraph. Any comments?

MR. LEE: This is not a soft peddle or any variety except for try to directly reflect what I think we've agreed to do in terms of when we make

recommendations to the governor or legislature. We aren't saying which path it should go, and it's trying to spell that out a little more heartfully.

CHAIRMAN ENTHOVEN: Peter, with all due respect to distinguished wordsmith and lawyer and scholar, I just found it awfully complex. I mean when I got through with the paragraph, I wasn't sure what it said that was different.

DR. KARPF: Could we straw poll the original?

CHAIRMAN ENTHOVEN: We better move along faster before we lose our troop. All in favor of retaining the original language -- let me just ask have we got enough of our quorum back here?

Members in the back of the church come up to your front pew please. Mr. Ramey, please get up here.

So we're going to take this in the opposite order. All those in favor substituting Peter Lee's language for the original language please raise your right hand.

MS. SINGH: You're looking at page 3.

CHAIRMAN ENTHOVEN: First full paragraph.

MS. SINGH: It starts with "implementing the Task Force's recommendations will require." Mr. Lee's proposal is to delete that and substitute it with his last recommendation.

CHAIRMAN ENTHOVEN: Helen, did you have a

question?

DR. RODRIGUEZ-TRIAS: Yes, I have a question of Peter. Peter, could you give me a capsule substance here?

MR. LEE: Withdrawn, I thought it was a better one, but at this point let's move on.

DR. RODRIGUEZ-TRIAS: Because the other one is shorter, and I think it says the same thing.

CHAIRMAN ENTHOVEN: Now, Ron Williams's language right after Roman numeral II the following sections -- does everyone have Ron's section?

MS. GRIFFITHS: Question on it.

CHAIRMAN ENTHOVEN: Yes, Diane.

MS. GRIFFITHS: The sentence concludes by saying but rather from the source materials included in the body of the report, I think the term "in the body of the report" could it be potentially ambiguous? Those of us sitting here would know what it means, but I think it would be clearer to use if you want to say Volume 1 or the findings and recommendations adopted by the Task Force --

MR. LEE: Included in this volume?

MS. GRIFFITHS: Well, the full report could obviously include --

MS. SINGH: It's the main report volume that she's referring to. Is there any objection to adding that language?

Members, at this point those in favor of

including Mr. Williams's language, please raise your right hand. I think there's 23, maybe 24. It's included.

CHAIRMAN ENTHOVEN: Bill Hauck.

MR. HAUCK: I don't know if this is in order, Mr. Chairman, even if it isn't I want to do it anyway. I want to move that we adopt the Executive Summary as is.

MS. SINGH: It's been moved by Mr. Hauck and seconded by Mr. Rodgers that we adopt the Executive Summary as amended. There's discussion.

CHAIRMAN ENTHOVEN: Nancy Farber?

MS. FARBER: I would agree to that if we deal with one further point that's on page 11, second paragraph, the final statement.

MS. SINGH: Just a moment.

CHAIRMAN ENTHOVEN: Page 11.

DR. ROMERO: Right.

MS. FARBER: "Denials of care must include a view by appropriately qualified credentialed individuals." Now we took a vote on this during our last meeting, and while this almost captures the intent of it, it's not quite there, and what I believe we voted on is the concept the denials of care have to be reviewed by somebody who has the same credentials by someone who is requesting to do that, and that doesn't quite say it.

MS. SINGH: There's a formal motion and a

second to adopt this, so any proposed amendments need to be done formally, Members, so if you want to make an amendment, please move to amend and use specific text.

CHAIRMAN ENTHOVEN: Nancy, which line are you on here?

MS. FARBER: It's the second paragraph under 10. Okay. So it's the very last line "Denials of care must include a view by appropriately qualified credentialed individuals." Since we're not going to be allowed to bring this up in the papers since the papers have already been voted on. And we're not going to go through them one-by-one, I want to point out to you that this doesn't quite factually represent what happened.

DR. GILBERT: That's actually --

MS. FARBER: I know but that recommendation isn't also exactly as I recall that motion, and I made that motion. We discussed it. We discussed it at length, and I know exactly what my intent was, and I'm saying that these words don't reflect that intent, and I would like you to correct it just as you've corrected other oversights.

CHAIRMAN ENTHOVEN: I think that if it's faithful to the document then we'll have to go with that.

MS. FARBER: But if you create that document after our last meeting, and I don't have the chance as the author of that motion have a chance to look at that motion until today, discuss it with this

group. That's not fair.

MS. SINGH: Ms. Farber, just to let you know, although staff are not perfect, we're all human, and errors can occur. We do have a pretty good safety check whereby I actually review the recommendations to the transcript to ensure that they are consistent with what the transcript indicates. In some instances the amendments are made with conceptual form. Generally, they're actual language, and so we use actual language. We do not take liberty to make any changes to them because we're basically going on what the Task Force members --

MS. FARBER: Well, I'm the author of the amendment, and I am stating for the record that what you put here is not quite the full intent, and that makes a substantial difference.

CHAIRMAN ENTHOVEN: All right. John Perez?

MR. PEREZ: Let me ask a question and then phrase a motion. Would it be appropriate for us to direct the staff to review the transcript prior to making final publication on this specific item and make the appropriate change if the transcript does not reflect what's written here? Would that be an overly burdensome thing to do in this specific instance?

CHAIRMAN ENTHOVEN: We think we have, but we agree to recheck it.

MS. FINBERG: Maybe Nancy wants to

purpose language that we can vote on --

MS. FARBER: You've done it for all the other issues, why not this one?

MS. SINGH: At this point, what we're doing, we're going through and changing a recommendation. I think staff have no problems or difficulties in cross-referencing the language with what was said in the transcript to ensure that it accurately reflects that; however, the recommendation has been already voted on.

MS. FARBER: Then I would like it noted for the record that you have treated this amendment differently than others, that you have substituted the author's wording for it. And I would like that noted.

CHAIRMAN ENTHOVEN: That's in the record. Fine. Helen?

DR. RODRIGUEZ-TRIAS: I'm sorry. I'm still on it --

MS. SINGH: Without objection staff will --

MR. PEREZ: And that will be part of the motion to approve it; right?

MS. SINGER: And we'll do it both in this Executive Summary letter and if there is a differentiation, we'll make it also reflected in the document.

CHAIRMAN ENTHOVEN: All right. Helen Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: Yes, mine is a different one. It's actually to reflect the recommendations on the women's paper more accurately than is done so on page 13, third paragraph, the fifth line from the bottom after 5B.

CHAIRMAN ENTHOVEN: The second full paragraph you mean?

DR. RODRIGUEZ-TRIAS: Yes, it's after 5B. 5B appears and the colon. Reads that "women be allowed direct access to their obstetricians and gynecologists." The actual recommendation was "plan shall be required to allow women direct access to the reproductive health care providers" to the physicians, et cetera. And so I would be content with just putting in the language that we did approve.

MS. SINGER: Can we say reproductive health care providers and leave it at that?

DR. RODRIGUEZ-TRIAS: You could. I think as long as you don't specify one type of provider.

MS. SINGH: I should just clarify this for Ms. Farber's sake. In this particular instance for the Executive Summary, staff summarized this to make it a little more palpable to layman's terms. We did add obstetricians and gynecologists, but the reproductive health care providers was the actual language in the recommendation which is reflected in the actual findings and recommendations.

DR. RODRIGUEZ-TRIAS: The thing is when

you added OB/GYN, you omitted everybody else.

CHAIRMAN ENTHOVEN: Okay. That's accepted. Maryann O'Sullivan and then Clark Kerr.

MS. O'SULLIVAN: Mine is along the lines of Helen. Katherine Dobbs with the American Nurses' Association submitted a letter January 2nd going over different areas in the document where we slipped again to physicians instead of provider, and we agreed and voted and all that, so could staff just take a look at that and -- thank you. Great. And then the other --

CHAIRMAN ENTHOVEN: The general point is to recheck physicians versus provider?

MS. O'SULLIVAN: Yes. Right. And then the others on page 3, the footnote, I want to ask that we delete that and maybe if we want to list these proposed names for a new entity, we put it in the second document because this was an informal questionnaire over the holidays, and apparently it looks like managed care authority came up pretty high maybe, but we actually voted as a Task Force against an authority. And so I think I prefer not to see that as confusing, and it makes it look like a Task Force authority.

MS. SINGER: What we tried to do here is we have one name that would be appropriate to a board and one name that would be appropriate to leadership by an individual for this reason because we didn't vote.

MS. O'SULLIVAN: Except we had a lot of discussion about an authority set aside from a board and

actually voted against an authority. We didn't vote on a board or not. We voted against an authority, so then to say the Task Force likes authority --

MS. SINGH: Perhaps at this point because there is a formal motion, your motion is to delete that footnote?

MS. O'SULLIVAN: Yeah.

MS. SINGER: Is it here and in the final recommendations or just here?

MS. O'SULLIVAN: I don't know if it's in the final --

CHAIRMAN ENTHOVEN: Maryann, I thought there was something fishy about a lot of the recommendations, there is agency for health improvement.

MS. BOWNE: I will second Maryann's, in a moment of good will, I will second her motion to delete the footnote on page 13.

MS. O'SULLIVAN: And in the text.

MS. SINGH: So delete the footnote and in the reference to the text. Okay. It's been seconded by Ms. Bowne. Those in favor please raise your right hand. Those opposed? Okay. The amendment has been adopted 28 to 0.

CHAIRMAN ENTHOVEN: I can't let this moment pass. Where's Ellen? She submitted the most popular entry, so I was going to present her with the prize. We have Ron Williams's motion made and seconded. No, I mean the motion to --

MR. HAUCK: Mr. Chairman?

CHAIRMAN ENTHOVEN: Yeah.

MR. HAUCK: Could I speak on my motions before we go any further here? My motion to --

CHAIRMAN ENTHOVEN: I'm sorry, Bill.

MR. HAUCK: I just want to say while everybody has worked real hard in looking at the language in this Executive Summary, this is not a Constitution that we're writing. The legislature is going to accept or reject what we've recommended primarily, I think, based on the consensus recommendation that we've made and words here and there are going to be lost in the volumes that we're going to present to the legislature and governor, and as I say I think the most important point is that they're going to choose to look at the recommendations that were made and particularly those that had some real consensus or were unanimous.

Once they've done some cost analysis of those, perhaps they'll reorder their priority, and then proceed to try to get some of those things done which is really what this was all about. I think the wordsmithing here is going to be lost completely on the legislature, and I haven't heard yet anything that's changed in any real way the recommendations that we've made.

CHAIRMAN ENTHOVEN: Bill, can I just reinforce that by saying in each of these sections staff

was on the telephone with the people who are most involved to negotiate out the wording to make sure they were satisfied.

MR. HAUCK: I'd like to see us proceed to adopting this with a vote so we can get on to the remainder of the business --

CHAIRMAN ENTHOVEN: We're at 3:25 now. We have 35 minutes before our proposed deadline. Jeanne?

MS. FINBERG: This will be quick. I would like footnote number 2 which is contained on page 4 to be put into the text. It's an issue of great importance to consumer group representatives, and it was something we discussed in a lot of pages, and we decided just to say it once to economize which sounds appropriate. But I'd like to see it up in the text as opposed to in a footnote.

MS. SINGER: But if it were in the text it would appear to be specific to the government regulation paper.

MS. FINBERG: Right, it doesn't have to be here necessarily. It can be somewhere in the Executive Summary to say what we meant when we're talking about stakeholders, so it doesn't have to go after this point.

MS. SINGH: Is there a second?

MS. SINGER: Well, can you specify where you'd want it?

MS. FINBERG: I guess perhaps it should go before the findings and recommendations in the introductory area. Would that be helpful?

MS. SINGER: So before Roman numeral II?

MS. FINBERG: Yes. Yeah, it could be a paragraph by itself just above Roman numeral II.

CHAIRMAN ENTHOVEN: Just above Roman numeral II?

DR. ROMERO: Just after.

CHAIRMAN ENTHOVEN: Well, we haven't even used the phrase "stakeholders" yet.

MS. FINBERG: Well, I thought that was Sara's point that if we wait to use the word then it would look as if it refers to that particular issue, so that we mention it generally it shows that it's a general comment to --

MS. DECKER: You've actually done this three times and that health plan is defined that way. The entity regulating managed care is defined that way and stakeholders is defined that way. And there are three terms that we use consistently as a term of art in the paper, and they're defined in footnotes, and I don't have a problem with the footnote approach, but I do have a problem that the one about regulating the state entity regulation is on page 9, and it's been used a lot before page 9. It's in footnote number 4, and it was actually used as early as page 6. So it's like there's three things that we're using as a term of art.

MS. FINBERG: How about managed care is not in the footnote. It's so important and makes sense to have it there. But the first example you gave is not a footnote, it's a paragraph.

MS. SINGER: What if we make a section that we call definitions or glossary?

MS. SKUBIK: If it's essential to understanding the paper, and it's put in a glossary section that won't be read, that isn't an effective tool.

MR. LEE: Put it after Ron's paragraph common terms, and then lead off with those three.

MS. SINGH: Is there an objection to that? See none, we'll go ahead with that.

CHAIRMAN ENTHOVEN: All right. This -- we really have to move on.

MR. KERR: This is quick. It's under the public perceptions in experiences of managed care on page 14 and 15. But look at 15 we have quite a discussion of the different types of problems that people have. One of the main findings the survey came up with certainly I've seen on the overhead, and so on. There are certain perceptions by people by type of plan they're in, so what I'd like to do in the very last sentence of that first big paragraph the one that starts, "the survey indicated that the likelihood of having a problem," that the first thing they put in is not health status, but the first thing would be to move

up the type plan of managed care in which the consumers enrolled, comma, health status would be second, and so on because otherwise we're losing a very major point I think.

CHAIRMAN ENTHOVEN: Okay. Without objection?

MS. SINGH: Is there any objection, Members? Are you ready to vote on the adoption of the Executive Summary --

TASK FORCE MEMBERS: Yes.

MS. SINGH: Thank you. Okay. Those in favor of adopting the Executive Summary as amended, please raise your right hand. Those opposed? The Executive Summary is adopted as amended 24 to 0. Congratulations.

CHAIRMAN ENTHOVEN: Now, I want to digress for just a moment since there was a promise of a bottle of wine to the person that submitted the most popular name, even though we wiped out the footnote and your excellent creativity Ellen is going to be expunged forever except in the transcript of the meeting.

I hardly dare mention it for putting it back, but it was California Managed Care Authority was the one that got the most votes from members in our straw poll. All right. Next, next we're going to discuss the Chairman's letter for inclusion in the main report, if I can find the Chairman's letter.

MS. SINGH: Members, that's tab 5B in

your packet, the Chairmen's letter for inclusion in the main report. And please note this is just a discussion item, that the Task Force did not vote to adopt or to require adoption of this document.

MR. PEREZ: Might I make a procedural suggestion here?

CHAIRMAN ENTHOVEN: Yes.

MR. PEREZ: Why don't we take item 5C before 5B since we are going to actually adopt 5C so that we don't waste time on discussion when we can actually be deciding on something that we have to adopt.

CHAIRMAN ENTHOVEN: Okay.

MR. PEREZ: I'm just asking us to change the order of consideration of 5B and C.

MS. SINGH: Is there any objection to that, Mr. Chairman?

CHAIRMAN ENTHOVEN: No, that's fine. Okay. I would like to move that we'll do a Dutch auction here and move this transmittal letter with Option C.

MS. DECKER: I'll second it.

MS. SINGH: Discussion?

CHAIRMAN ENTHOVEN: I'd like to have a vote on this one.

MS. SINGH: Mr. Chairman, is there any discussion?

MR. PEREZ: Could we just take a minute to read through all --

CHAIRMAN ENTHOVEN: Sure. Sorry, John.

MS. FINBERG: The difference between B and C is taken together, those words, is it? It seems that B is more supportive than C.

MS. SINGH: Members, is there any discussion on Option C which is before us right now? Ms. Bowne?

MS. BOWNE: Yes. With all due respect, I view Options A, B, and C as the choice of the same plan with different variations of the same plan which in some consumers' minds is not choice, and I think that this Task Force has worked on a simple majority, not a consensus. And with all respect because I know that, you know, we have worked long and hard, I think that the connotation of these is that there has been a consensus rather than a simple majority on many of these points.

Now, granted, some of them have been passed with a far more significant, you know, than just the 16 votes required, but I'm concerned about the connotation on this, and I don't know who is the author of these, but I do view it as a true managed care with one plan and three options.

MS. SINGH: So, Ms. Bowne, would you propose to amend that or are you speaking in opposition?

MS. BOWNE: I am speaking in opposition to Option C.

MS. SINGH: Mr. Shapiro.

MR. SHAPIRO: I have a question. I'm not

sure whether this document or some other document was reflected. One of the earlier decisions of the group was that in some transmittal to the governor and legislature it would indicate, and tell me if we've already done this, indicating that there were some issues that were not covered?

MS. SINGH: Mr. Shapiro, that was included in the Chairman's letter. The transmittal statement is simply a statement, here you go members of legislature --

MR. SHAPIRO: Fine, I'll wait for that.

MS. SINGH: Mr. Williams and then Dr. Northway.

MR. WILLIAMS: I would just speak in opposition to Option C and the reason simply put is without having an understanding of the cost implications of what we're proposing, it's hard to know what would really resolve in the substantial improvement and the functioning of acceptability.

MS. SINGH: Thank you. Dr. Northway?

DR. NORTHWAY: Alain, could you tell me what you were envisioning in your difference between B and C?

CHAIRMAN ENTHOVEN: Let's see, it's that in --

DR. NORTHWAY: One we agree, the other we join in.

CHAIRMAN ENTHOVEN: Yeah, join in

recommending, that we recommend the package. That was the idea. I realize it's a fine distinction. I was just trying to find out, and I'm open for ideas for how to do it, but the idea to, you know, see if there's a little stronger endorsement than we would --

MS. SINGH: Is there any other discussion on Option C before we vote on it? Okay. Seeing none, Members, those in support of adopting Option C please raise your right hand. Those opposed? 19 to 5 -- 19 to 6 Option C -- I believe I got you, Mr. Gallegos. The Option C has been adopted.

DR. ALPERT: So at this point, Mr. Chairman, we move to the Chairman's letter.

CHAIRMAN ENTHOVEN: This is merely for discussion. Can we just run through this fairly quickly?

MR. HAUCK: I just want to raise the question of why we review this at all?

MS. SINGH: This was requested by the members at the November 21st Task Force meeting that we put this on the agenda for the Task Force --

MR. HAUCK: I'm still raising the question why do we need to review your letter? It's your letter. It's your name on it, and what you say is clearly --

CHAIRMAN ENTHOVEN: There was another letter that was my personal letter that I thought was unreviewed by the Task Force that had to have a change

or two, so I don't want to be running rough shot --

MR. PEREZ: At the risk of agreeing with Bill Hauck again --

CHAIRMAN ENTHOVEN: Let me just say that one thing is that a lot of this language tracks language that was in the Executive Summary. Now we've modified the Executive Summary, so I'd be very happy to go back and conform this to that.

MR. HAUCK: You should write the letter you want to write, and we should go on to the next item.

MS. O'SULLIVAN: Dr. Enthoven, I want to track one other thing that's in the Executive Summary into the transmittal letter if you are interested in doing that, and it's on the bottom page --

MS. SINGH: Ms. O'Sullivan, are you referring to adding additional language to the transmittal statement, not the Chairman's letter that we're on now?

MS. O'SULLIVAN: I am. Sorry, now we voted on it, and I'm proposing that we --

MR. PEREZ: You would like to append to.

MS. O'SULLIVAN: Thank you. That's what I want to do. It's language that we discussed a lot here, and it's on page 2 of the Executive Summary, the third paragraph from the bottom. There's a sentence in the middle of the paragraph that starts "In addition." I would take out "in addition," and just start the sentence "the Task Force did not cover other important

topics due to time constraints posed by the requirements to report back to the government and legislature by January, '98." It's that language that says the report was due.

CHAIRMAN ENTHOVEN: Let's see, you're on page 2 of the Executive Summary?

DR. ROMERO: The third paragraph, the second sentence, begins "In addition."

MR. ZAREMBERG: Alain, I support that if we had it in the transmittal letter we said we didn't have the cost implementations. I would be in support of that particular sentence too.

MS. SINGH: So first of all, we don't have a second on Ms. O'Sullivan's amendment.

Mr. Zaremberg, I believe that you're amending -- you're adding additional amendment to cover the cost issue?

MR. ZAREMBERG: That's correct, and if we didn't address all issues including the costs of the recommendations.

CHAIRMAN ENTHOVEN: I think we say these points elsewhere, it doesn't have to be said again, with all due respect.

MR. ZAREMBERG: She's amending the transmittal letter, and I don't have a problem with that as long as --

MS. SINGH: So, Mr. Zaremberg, I just want to state you'll second Ms. O'Sullivan's amendment

with the caveat that we add that we weren't able to address costs as well. Is there any discussion?

MS. O'SULLIVAN: I don't think that's a friendly amendment.

MS. SINGH: Ms. O'Sullivan, I just want to move us along here. Ms. O'Sullivan, you still require a second, and Mr. Zaremberg still reserves the right to make that amendment.

MS. FINBERG: I'll second her amendment without the cost.

MS. SINGH: Is there any further discussion? Mr. Zaremberg, do you want to amend this to include the cost?

MR. ZAREMBERG: Yes, I think we're going to indicate. This is in regard to the transmittal letter?

MS. SINGH: It's been seconded by Mr. Williams. Is there any discussion on Mr. Zaremberg's amendment?

MR. SHAPIRO: What's being proposed?

MS. SINGH: We're talking about the transmittal statement at this point. Ms. O'Sullivan is making motion to amend the transmittal letter.

MR. RODGERS: Question. Does the transmittal letter, is it going to be bound with the document or does it appear on top of the document as just a document --

MS. SINGH: It appears on top of the

document as a transmittal document -- letter.

MR. RODGERS: So it might be thrown away --

MS. SINGH: Mr. Perez?

MR. PEREZ: The Executive Summary is so short and concise and reflects so effectively most of what we discussed that I really think adding anything else to the transmittal letter gets us back in debating the minutia we've already gone through, and while I agree with the intent of what Ms. O'Sullivan is trying to get across, I think in the interest of time we ought to vote down both Ms. O'Sullivan's and Mr. Zaremberg's amendments.

MS. SINGH: Is there further discussion? Seeing none, those in favor of adopting Mr. Zaremberg's amendment first -- actually, we have to go in the order with which the motions that were made --

MS. O'SULLIVAN: I'll withdraw my amendment.

MS. SINGH: Thank you. So, Mr. Chairman, I believe we finished discussion on the Chairman's letter, so we need to move on.

CHAIRMAN ENTHOVEN: Next we get to Item D: Consideration and discussion of the following proposed statement, "All entities which contribute to medical decisions effecting health care should be accountable for their impact on medical decisions."

Let me just first explain to you how this

got on to the agenda. Shortly before we reached the; that is, within hours of reaching the deadline for the ten days' notice and sending to the printer, et cetera, I received a telephone call from Diane Griffiths, and she said to me that she had 16 people who had signed on and faxed to her their signature on this statement. So I was -- found myself in a situation of having to make a judgment call. She said she's got these statements signed, and she requests that I use my authority as chairman to put this on the agenda without putting her to the trouble of making this into a petition from 16 members to put it on to the agenda.

I had some reservations about it. I mean, Diane, what went through my mind is when you said, "Well, this is something that we considered, voted on, debated, and decided, and we did not make any provision for reconsideration later on," and I was just concerned that this would be reopening a previous issue.

Nevertheless, I felt that the right thing to do was to put it on the agenda because I thought it better to deal with this in an open and democratic process rather than to rely on the rules to keep it off the agenda when it is a, like they say, kind of in the gray zone. But moreover I'd like to say I appreciate very much Diane's fair dealing and straight-shooting through the whole Task Force process, and I felt that this was the fair and right thing to do. So that's why I put it down.

Diane, did you want to comment?

MS. GRIFFITHS: I'd like to comment on the procedure just to indicate that the Task Force rules do allow majority of the Task Force membership to request that something be put on the agenda, and I was simply suggesting to you that instead of going back and getting 16 additional documents that said that, instead of just supporting the statement, that we could just save ourselves a little bit of time and do that. And so --

CHAIRMAN ENTHOVEN: Okay. That's exactly right.

MS. BOWNE: But, Alain, excuse me with all due respect before you're complimented on your fair dealings, there were others of us that didn't know this was afoot, that took that since we had voted on this notion and variations of it, I believe certainly five if not eight or ten times at the last meeting that the issue was closed. And obviously there are several of us that did not know this was coming about until we received the packet in the mail to know that others of you, 16 others of you had determined that you wanted it on in this manner. And I think if we were truly to have done this in a fair and open manner, it would have been circulated to all of the Task Force members so that we could all know and be prepared for this discussion.

MS. GRIFFITHS: I think it was. The fact of exactly what would be proposed is here on the agenda,

and obviously many members on the Task Force felt free to circulate statements and get signatures to a select number of members of the Task Force. There were many, many letters organized amongst those who opposed other recommendations that were not circulated to other members. So that practice was followed in this situation just as it was in the minority, many minority statements that were signed by multiple members.

MR. HIEPLER: We'd be happy to provide you with a declaration, if you'd be happy to sign it now.

MR. PEREZ: In fact, we already signed for you, Rebecca.

CHAIRMAN ENTHOVEN: Dr. Brad Gilbert.

DR. GILBERT: I don't want to comment on process. I want to comment on substance for two reasons. One is that I signed the letter. But more fundamentally I didn't have the opportunity to discuss the last time I'm probably the only person at this table that makes the kind of decisions that we're talking about. And I'm very clear about three things, and I had a lot of time to think about it and find myself written up in the newspaper for being in the bathroom when actually I was on a plane.

But there's three things that I'm clear about. Number one I make medical decisions. I make coverage decisions as well, but as the medical director making determinations of medical necessity I am making

medical decisions. The second is that I need to be accountable for those decisions. I need to be accountable because I'm weighing and taking into account someone's health care and making a decision that may have a deleterious effect. So I'm quite clear that I should be accountable.

But finally the thing that's caused me the most troubling thoughts on this issue is that I see those decisions as fundamentally identical to what I've done as a practicing physician. When I make a medical decision as a medical director I try to get every bit of information I can regarding the medical status of a person. I get all the medical records, et cetera, et cetera. It's in fact often a more difficult decision because the patient's not in front of me. I'm not always dealing with that patient. I discuss it with the physician who is responsible for their care, but I have to make the decision somewhat in absentia. That makes me take it even more seriously and in fact find consistently on the side of the individual because I know I don't have all the information.

So those three things when I think about those three things, that the medical decisions that I need to be accountable, but that are no different than I did as a practicing physician, just different in terms of subtly in terms of not being directly related to the patient.

I, at this point, believe there need to

be modifications to the general statement that I originally signed on. And the reason for that is I've seen editorial after editorial that has taken that general statement and changed it in ways that I'm uncomfortable with, and fundamentally because I see those decisions as identical to what I would do as a physician. And so although having signed on the letter as a general statement, and I know these modifications were discussed at the prior meeting and apologize if I'm repeating, I wasn't here, I was having fun with my wife on my an anniversary.

MR. LEE: You should have stuck with the bathroom.

DR. GILBERT: And the two, the modifying statements were brought up before, and I don't know whether the majority of the Task Force supports them or that you're accountable for what you do in terms of the medical decisions meaning in the language is in proportion to their involvement in the medical decision and subject to recovery limits that are otherwise applicable to medical decisions because I see these as identical. So I cannot support the general statement after much thought and consideration as an individual who makes these decisions.

MS. SINGH: Is there any further discussion? Mr. Perez?

MR. PEREZ: I've got a question here, it happens to be a statement that I didn't sign on to, but

I agree with. I'm just trying to understand what we're considering it for?

MS. SINGH: That's before this Task Force.

MR. PEREZ: Where?

CHAIRMAN ENTHOVEN: Recommendations are closed.

MR. PEREZ: This is a statement that I'm absolutely in support of. It's one that I haven't been privy to until we got these packets. I'm just trying to understand where we place this because if there's a place where we can place this, you know, I'd be willing to go through the process of voting on it. If there's not, I don't want to just have a debate about the merits of this statement and not see it placed anywhere.

CHAIRMAN ENTHOVEN: John, the information that I was provided with said that you were one of the 16 signatories.

MR. PEREZ: Then maybe I did sign it.

MS. SINGH: Ms. Griffiths and then Dr. Alpert.

MS. GRIFFITHS: Mr. Chairman, when we discussed this, we clearly discussed this with an understanding that we would be contemplating this as an additional recommendation as the Task Force. I'm shocked to hear that your position is that the recommendations are closed and this could not be added to the recommendations.

CHAIRMAN ENTHOVEN: Well, by that I meant we can't go back and put it in the previous documents which we've completed, but it doesn't -- I mean, if you are suggesting that we put it in the Chairman's letter, the transmittal, that's open for discussion. I mean, I think that we cannot consider reopening the previous documents that have been done and wrapped up because --

MS. SINGH: That's a parliamentarian also standard, Members. We voted to adopt or to not adopt several sets -- many, many sets of recommendations and if this were to be included, for example, the practice of medicine papers recommendation, then this would have to be considered under reconsideration, which it is not. Reconsideration can only be requested at the time the motion fails. Reconsideration was not asked at that time. It does not mean a vote has to be taken at that point, but reconsideration must be asked for at the time that the motion fails. This motion failed. Reconsideration was not asked.

MS. GRIFFITHS: Mr. Chairman, if I could respond please. When you and I discussed this, we discussed it in terms of being an additional recommendation. In fact, you asked me if I would be willing to go along with a very simple motion to move this adoption of this, ask someone else to second it, and take a vote, and not to reopen this debate, and I said I would certainly be willing to do that. But the conversation we had certainly contemplated that it be

put in the recommendations.

If it's your position that we're going to use some kind of procedural shenanigans to keep that from happening, then the record will stand for that. Clearly the agenda was put together in a fashion that if you were going to have that kind of procedural problem with what we talked about when you and I spoke, then I feel you should have let me know about that. But you're the Chair and --

CHAIRMAN ENTHOVEN: Look, Diane --

MS. GRIFFITHS: You're going to have that kind of ruling, the record will stand for it.

CHAIRMAN ENTHOVEN: If I wanted to deal with this to use your expression "a procedural shenanigan," it wouldn't be here. I could have just said I don't have the petition before me.

MS. GRIFFITHS: That would have been preferable from my point of view than for you to led me to believe that we would have had this recommendation from 16 members of the Task Force.

CHAIRMAN ENTHOVEN: I don't recall any discussion about -- we were going to put this to discussion and possibly to vote on. I don't recall any discussion about exactly where we were going to put it, and afterwards when I asked --

MS. GRIFFITHS: I recall that. You asked me whether I would be satisfied with it being in the Chairman's letter, and I said no, I thought it should go

into the Executive Summary. And you did not disagree with that, and in fact your focus with me was on me trying to keep the controversial of this to a minimum, just put it off and let it be voted on.

CHAIRMAN ENTHOVEN: Well, where do you want it to go because my parliamentarian tells me we cannot put it back in the document.

MS. GRIFFITHS: Well, I think that the agenda has been put together to ensure that result, but I -- as you and I discussed when you and I were on the phone the appropriate place for this would be at least in the Executive Summary. I think it's probably quicker just to put it to a vote and then deal with where it might go subsequently.

CHAIRMAN ENTHOVEN: Diane, I just want to assure you I'm not trying to deal with this as a procedural shenanigan, honestly. I'm trying to balance these conflicting advice.

MS. GRIFFITHS: We had an explicit conversation about where this would go in the Chairman's letter, and I suggested it at least should be in the Executive Summary, and you did not express any disagreement with that or suggest it would not be possible to put it into the Executive Summary.

CHAIRMAN ENTHOVEN: Well, would there be any objection to -- Will?

MR. HAUCK: At the risk of interrupting your debate with Diane here, if Dr. Gilbert, by what he

has just said is not going to vote for the statement, I would presume there are not 16 votes for it, so the discussion you're having is a moot point unless we're going to vote on alternative language, and then we can debate where that goes.

MS. FARBER: You're presuming that other people who haven't seen it until today are going to vote against it.

MR. SHAPIRO: We should take a straw vote.

MS. SINGH: Members, you can take just a straw poll vote on whether or not you support the statement. We're not discussing where it would be placed, just simply that you support the statement.

MR. HIEPLER: This was as Chairman Enthoven mentioned probably one of the more lengthy debates, and I was shocked that with the most benign neutral language as in, and this is even more benign, that there was not agreement that someone was saying you shouldn't be held accountable, and whatever that means that the people contributing to health care decisions should not be held accountable. This is even more watered-down, yet I think it's important because otherwise we ditched one of the most important issues that has caused the Federal commission to be criticized for because they haven't addressed this. They haven't looked into it. They haven't said a word about it. And I think that we are doing a great disservice if we do

not at least address this, and to the degree of people in good conscience can somehow vote against it, fine, we'll let that debate go on. But this is so straightforward, so benign, that somewhere it should be included; otherwise it's go to look as if we abdicated our duties to patients, doctors, and to HMOs.

CHAIRMAN ENTHOVEN: Allan Zaremberg.

MR. ZAREMBERG: With all due respect to Mr. Hiepler, I don't think the language is benign because it is subject to interpretation. And with all due respect, to Ms. Finberg who is sitting next to me, she was quoted in the Sacramento B as saying her interpretation of what it meant was medical malpractice liability against the plans without regards to limits, so I think Mr. Hiepler's recommendations -- well, close to it, and I think what one interpretation somebody brings to it is, I think, something that we should be considering, and if we want to say it's without regard to limitations, we should say that, and I think some people interpret it this way. And so I don't think it's benign language, I think it's intended to be drafted in such a way that people can interpret it to be without regard to limits, and so I would just like to disagree that this is benign language.

CHAIRMAN ENTHOVEN: Okay. Zatkin?

MR. ZATKIN: I'd like to agree with Allan Zaremberg. Much of the debate we had last time had to do with the parameters around which accountability would

occur, and I think Dr. Gilbert made the point very well that if we're going to hold plans accountable for their involvement in medical decisions, we ought to apply the same rules and limits that otherwise apply. And that's exactly what Dr. Gilbert's statement does, so that the more benign general statement in the absence of being specific on this issue would I think not indicate a clear Task Force intent.

CHAIRMAN ENTHOVEN: Okay. Terry Hartshorn and then Bud Alpert.

MR. HARTSHORN: I guess I also agree that these are not benign words because they're going to be used to certain people's benefit, and they're going to be used against others. If -- now, I need clarification on what we're voting on, one, is it with Brad's amendment, and if that's true, I guess I would like to amend that we put in it the individuals also. It's not just entities, but there's a lot of individuals that contribute to medical decisions.

MS. SINGH: Mr. Hartshorn, I believe we're just looking at the statement as proposed without any amendments made.

MR. HARTSHORN: Then it's not a benign few words.

CHAIRMAN ENTHOVEN: Bud Alpert.

DR. ALPERT: Few things, I think what Brad said is very, very important because what he did is added his name to a list of people that have testified

here that said accountability for and in this case it was health plans and in his case he was speaking as a medical director, and essentially for all entities which, by the way, it includes individuals is the way we defined it, and the way it's defined in the dictionary. And so -- but I think when we asked Margaret Stanley what's the most important thing we should do, and she said deal with accountability.

Pat Powers from PBGH made a big point about accountability at a conference I went to. Ron Williams here has referred to accountability several times, Arnie Southum has and now Brad Gilbert. I think everybody around the table realizes that accountability is a big issue, and the question is I personally -- I don't want to say we took a snapshot, and then didn't look at it. I want to say we took this snapshot and saw this big problem.

We saw there's a big principle in society that needs to be corrected, and then we can say where correcting it is not so simple, and these are the different sides and their contentions. I think simply saying those things is much better than being accused -- it's like being asked whether the biggest problem is ignorance or apathy and saying, "We don't know, and we don't care."

I think we need to acknowledge that we saw the snapshot, and with that in mind I would say we ought to take a straw poll on both languages -- on the

languages as proposed here and how it's stated, and then on Brad's language and see what that shows.

CHAIRMAN ENTHOVEN: Okay. Brad's language being with --

DR. GILBERT: What Sara's telling me in my ear all entities which contribute to medical decisions effecting health care should be accountable for their impact on medical decisions which is identical. In proportion to their involvement in the medical decisions, they're accountable for what they do and subject to recovery limits that are otherwise applicable to medical decisions.

So if I'm a doctor, I'm a doctor making medical decisions.

MS. SINGH: Dr. Gilbert, I have a procedural question for you. What are you making a motion to amend --

DR. GILBERT: To amend the language.

MS. SINGH: Thank you.

MS. BOWNE: Second.

MS. SINGH: Dr. Gilbert, would you read that slowly for the record please.

DR. GILBERT: Forget the first part. In proportion to their involvement in the medical decision and subject to recovery limits that are otherwise applicable to medical decisions.

CHAIRMAN ENTHOVEN: Once more Brad in proportion to their --

DR. GILBERT: Involvement in the medical decision and subject to recovery limits that are otherwise applicable to medical decisions.

CHAIRMAN ENTHOVEN: So that's an amendment to Diane's language.

MS. SINGH: So basically what you're asking, Dr. Gilbert, is you're moving to -- what are you moving to -- there just hasn't been a formal motion.

MR. PEREZ: Might I make a procedural motion here, Mr. Chairman? Instead of amending something that hasn't been moved and since we were going to take a straw poll anyway, why don't we take a straw poll on each of the two sets of language and move from the language that was on there.

MS. GRIFFITHS: I have a question first regarding the meaning of his language. Brad, did you say recovery limits that are otherwise applicable, you don't mean that this issue should be studied, you mean simply and straightforwardly that this should apply? Or do you mean that in the last ground of discussion we had various iterations, one of which, included looking at the issue of recovery limits and the other which included applying it directly?

DR. GILBERT: From my perspective, I see the two medical decisions whether I make it as a clinician with a patient or I make it as a medical director as a medical decision I see it as identical and therefore they should be treated the same.

MS. GRIFFITHS: So you're not suggesting that the governor and the legislature look at that issue but rather that your support for the accountability standards condition on the applicability like that?

DR. GILBERT: I'm suggesting that -- what I'm saying if I'm going to be accountable, I should be accountable in identical manner whether I make the decision here or here because they're an identical decision.

MS. SINGH: Members, is there any further discussion before we just simply take a straw poll vote on what I believe we should probably start with Mrs. Griffith's language.

MR. HARTSHORN: I have a question -- does entities include individuals? Do we have the definition someplace because you've got individual practitioners. You've got lots of individuals that aren't entities.

CHAIRMAN ENTHOVEN: We understand entities includes individuals.

DR. ALPERT: But you can put it in like that.

MS. SINGH: Entities including individuals. All right. This is a straw poll vote, Members, of Mr. Zaremberg --

MR. ZAREMBERG: This is a point so I know what I'm voting on. Entities applies to things that are regulated under E.R.I.S.A., so we're talking about third-party administrator union, union pension plans. I

just want to make sure I know what I'm voting on; is that intended to be inclusive in this?

MS. SINGH: Dr. Gilbert would need to --

MR. ZAREMBERG: Brad is the author, so I just want to make sure I understand.

MS. SINGH: Without any further delay, we'll do a straw poll vote on Dr. Gilbert's proposed language.

TASK FORCE MEMBERS: No, no.

MS. SINGH: All right. We're hearing -- we'll start with Ms. Griffiths's language because it was the first language discussed. Those in favor of supporting Ms. Griffiths's language as proposed please raise your right hand. This say straw poll vote, but we still need 16 given we have 30 here.

Although, okay, you have 14 so Ms. Griffiths's statement would not be adopted should it be formally moved.

All right. A straw poll vote on Dr. Gilbert's language please raise your right hand in straw poll vote. Again you would need 16 votes members.

All right. Again you have only ten votes. So this is all straw poll votes at this point. Dr. Alpert?

DR. ALPERT: Since I think this is such an important issue, and again I'll say that everyone around the table here agrees that accountability should be equal. I'd like to -- except for Rebecca which she

doesn't. I'd like to call people's attention, if I might, to the Chairman's personal letter which is under the section letter submitted by the Task Force members, et cetera, et cetera, not the Chairman's letter on page 5 where he refers to tort liability, and I don't want to speak for the Chairman, but I'm going to paraphrase what I think his intent was.

And as I see it, he was trying to say that this was a contentious issue, and that he voted against it, but that it wasn't that simple, that he looked at this snapshot and saw there was a problem, and that's how he starts. And then -- but then his constituency deserves the explanation why he voted against it.

I'll read the beginning of it. It says, "I do agree with the proposition that people's procedural rights ought to be the same whether they work for private sector employers under E.R.I.S.A. or not, and whether they have been injured by negligent actions caused by any of the variety of entities that contribute to medical decisions. And I agree that there must be some sort of accountability." Period.

And then he goes on and explains why his view of how the tort system works as a way of regulating accountability and in medical care and the practice of medicine is not a good saying, and he makes some other recommendations, a lot of points which I think are terrific, and that's his explanation.

Again this is a no vote on the way things were worded but identifying there was a problem there and that he does think people ought to have the same access to procedural rights. I think the way he just worded this, what I just read, is even more balanced than the two things that we couldn't do. And I'll just read it again substituting "we" rather than "I."

"We agree that the proposition that the people's procedural rights ought to be the same whether they work for private secretor employers under E.R.I.S.A. or not, and whether they have been injured by negligent actions caused by any of the variety of the entities that contribute to medical decisions. And we agree that there must be some form of accountability."

The reason why I think that language is a bit more balanced is because if you look at the two opposite sides, the limits versus no limits, and it's used what Mr. Zaremberg was talking about, the implications or the inferences which is really what they're talking about that other people will take? Here there is -- first of all, the word "limits" is never mentioned at all. On the other hand, there is a wording that links procedural rights being the same with regard to medical decisions in the form of accountability.

To me, it links if you're talking about implication or inference, neither of which he was trying to do by the way. He was saying that he thinks people ought to be accountable, and he thinks it would be

difficult because of the inequities on the other side that was his opinion. But the way he worded it I found very softer on both sides in terms of presenting the concept and not leading to the types of inference that Mr. Zaremberg appropriately said people may come to, and that's what people on that side would be afraid of.

And as an alternative I'd like to see a straw poll of simply -- with the Chairman's permission, of using his language and inserting that in wherever we decide to insert it as a statement of this concept.

Now subsequent to that, if we want to say we couldn't go further when we looked at this because of the contentious nature of it. I think that's fine. I think that explain it.

CHAIRMAN ENTHOVEN: But I would object very strongly to taking my sentences out of context. I mean the context is that I oppose any extension of the tort system to the field of medical injuries because I believe for all the reasons stated and many of which you agree, I think that it is -- it's the wrong way to go. It's a very destructive force in medicine, you know, as Dr. Dickie says she and other doctors can't tell the truth to their patients because they're afraid of being sued. And so I would insist if you're going to use my words that the whole paragraph be used and not taking it out of context. Ron?

MR. WILLIAMS: Yes. This is clearly a very difficult issue. I think evidenced by the fact

that the Task Force has debated it and discussed it several times including today, I think we've had straw polls. I think the group has been unable to come to a consensus because it is a difficult issue. I think the issue has been given very fair consideration as a result to the time we've invested previously and today. And I would move that we move on to the next agenda item and take the remaining time, if any, to hear from the public at large and comment.

MS. SINGH: Members, I feel that it's necessary for me just to clarify procedural aspects of this issue. I was not pinpointing Ms. Griffiths's particular recommendation. This would be true of any recommendation that failed that was not granted reconsideration at the time of its fail. It's not just this particular issue at hand. My statement would be a blanket statement for any such situation.

MR. HIEPLER: I would like to make a motion based on Dr. Alpert's comments that we take a vote on the language as he's proposed and we can ignore where it came from if you like.

MR. PEREZ: Second.

MS. SINGH: I believe at this point, Members, as the author of the language, the Chairman can object to his actual verbiage being placed in a motion.

MR. HIEPLER: What's the authority for that? We made it "we" and not "I." We changed it. It's Bud Alpert's language.

CHAIRMAN ENTHOVEN: I don't think it's fair play to take some of my words out of context without looking at the whole paragraph.

MS. FARBER: You know, I couldn't agree with you more. I wish you had accorded me the same courtesy.

DR. ALPERT: The intent was not to impact it all. You know, your argument, much of what you said, I agree with it.

MS. SINGH: You need a two-thirds vote to call the question. Members, there's been a motion -- is this what I understand, Mr. Hiepler, you've moved to adopt language? I mean, we don't really -- I'm unclear what you're proposing to do, if you could help me with that.

MR. HIEPLER: After Dr. Alpert discussed what he discussed in the language that he used, I am moving that that language be used and inserted in the Executive Summary, and Mr. Perez seconded that.

CHAIRMAN ENTHOVEN: You want to read it?

DR. ALPERT: I must say I am quite sympathetic with the Chairman's point, and as Nancy said it's not my intent to pirate anything away from the Chairman. It's a compliment of the use of his description in a more balanced way to communicate something, and I think the Task Force wants to communicate without having to go any further then arguments can be presented. So I would say with the

Task Force that we agree or we feel that people's procedural rights ought to be the same whether they -- do you have it in front of you the rest of it?

MS. SINGH: No.

DR. ALPERT: Task Force feels that people's procedural rights ought to be the same whether they work for private sector employers under E.R.I.S.A. -- that's in parentheses -- or not and whether they have been injured by negligent actions caused by any of the variety of entities that contribute to medical decisions. And the Task Force agrees that there must be some form of accountability, period.

MR. ZAREMBERG: Could I make a point on that, if I might, and I think this suffers from the same perspective that we discussed, and Dr. Alpert indicated that language is subject to interpretations, and I think Dr. Enthoven's language is quite clear as to what he means if you went further.

MR. PEREZ: I've called the question.

MS. SINGH: In order to call the question we need a second and a two-thirds vote to limit debate. There's been a motion. Is there a second?

MS. FARBER: Second.

MS. SINGH: Those in favor we need 20 votes, Members, to call the question.

MR. PEREZ: This is purely a motion to terminate debate.

MS. SINGH: Those in favor of calling the

question raise your right hand. You have 17 votes.

MR. ZAREMBERG: I'd just like to finish that. And I think Dr. Enthoven's statement is subject to qualification as he continues on in his paragraph. And I think by not doing it, it suffers from the same issue that we discussed before that it is subject to interpretation without being specific as to what is meant by this, and different people mean different things, and we ought to be clear as to what we mean by these statements.

MR. HIEPLER: I think under that same proposition that you brought forward our whole job here as the Task Force is not to legislate, but to reflect what everybody has told us, and what we've heard in testimony. So we're not saying we're working out any detail. This is not giving anybody license to do anything other than a recommendation as to where we feel there are problems as to what Dr. Alpert said. So we haven't legislated the detail of any of these propositions whether they're considered ones that you support or ones you're against, and this is just another issue saying we addressed it. We don't want to duck our heads and abdicate our responsibility to make some general recommendations.

MS. SINGH: Is there further discussion, Members? Dr. Alpert?

DR. ALPERT: I would just say with regard to that, as one of the initial authors of the initial

statements that then had inference placed on it, I have to say that I had no intent about the concept of limits either for or against. And I would have voted for both concepts because I think that's something downstream from the point I'm trying to make.

Actually in a very innocent fashion it's not seeming to be so now as it's being cast, but I'll tell you I thought this was written so well and balanced taken on its own that it could stand that way. And then you could explain it the subsequent explanation about why he voted one way or another could have actually gone on either side.

CHAIRMAN ENTHOVEN: When we got started on this, we said first we would consider Diane's language, and then we would consider Brad Gilbert's.

MS. SINGH: Now we have a third.

CHAIRMAN ENTHOVEN: Now we have a third.

MS. SINGH: Just for clarification purposes, Mr. Hiepler, you have moved to adopt this language and include it in the Executive Summary. Members, please note that if this is included in the Executive Summary it can only go in the introduction section as a statement. That's pursuant to our rules. Those in favor --

MR. PEREZ: And I asked for it to be a roll vote, so I'm just asking that we do it now instead of going back and ask people to go on the record.

MS. SINGH: We will have a roll call

vote. Is everybody clear on the statement that is up for adoption at this point in time?

CHAIRMAN ENTHOVEN: Okay. Dr. Alpert's words would be, "We feel that people's procedural rights ought to be the same whether they work for private sector employers under E.R.I.S.A. or not and whether they have been injured by negligent actions caused by any of the variety of entities that contribute to medical decisions. And the Task Force agrees that there must be some form of accountability.

MS. SINGH: Okay. Members --

CHAIRMAN ENTHOVEN: That's his words, not mine because my important qualifications in the next sentence have been deleted.

MS. SINGH: And now it's the motion was made by Mr. Hiepler. All right. The motion is on the table. It's been seconded. Those in favor of --

MR. PEREZ: It's a roll call.

MS. SINGH: All right. I apologize. Please say "aye" if you support the adoption of the statement for the inclusion in the Executive Summary in the introductory section. Alpert?

DR. ALPERT: Yes.

MS. SINGH: Armstead.

DR. ARMSTEAD: No.

MS. SINGH: Bowne?

MS. BOWNE: No.

MS. SINGH: Conom?

DR. CONOM: Yes.

MS. SINGH: Decker?

MS. DECKER: Pass.

MS. SINGH: Abstain or pass?

MS. DECKER: Pass.

MS. SINGH: Enthoven?

CHAIRMAN ENTHOVEN: No.

MS. SINGH: Farber?

MS. FARBER: Yes.

MS. SINGH: Finberg?

MS. FINBERG: Yes.

MS. SINGH: Gallegos?

(No audible response.)

MS. SINGH: Gilbert?

DR. GILBERT: No.

MS. SINGH: Griffiths?

MS. GRIFFITHS: Yes.

TASK FORCE MEMBERS: Gallegos is on the phone.

MS. SINGH: Excuse me. Hartshorn?

MR. HARTSHORN: No.

MS. SINGH: Hauck?

MR. HAUCK: No.

MS. SINGH: Hiepler?

MR. HIEPLER: Yes.

MS. SINGH: Karpf?

DR. KARPF: Yes.

MS. SINGH: Kerr?

MR. KERR: Yes.

MS. SINGH: Lee?

MR. LEE: Yes.

MS. SINGH: Northway?

DR. NORTHWAY: Yes.

MS. SINGH: O'Sullivan?

MS. O'SULLIVAN: Yes.

MS. SINGH: Perez?

MR. PEREZ: Yes.

MS. SINGH: Ramey?

MR. RAMEY: No.

MS. SINGH: Rodgers?

MR. RODGERS: No.

MS. SINGH: Rodriguez-Trias?

DR. RODRIGUEZ-TRIAS: Yes.

MS. SINGH: Schlaegel?

MR. SCHLAEGEL: No.

MS. SINGH: Severoni?

MS. SEVERONI: Yes.

MS. SINGH: Spurlock?

DR. SPURLOCK: No.

MS. SINGH: Tirapelle?

MR. TIRAPELLE: No.

MS. SINGH: Williams?

MR. WILLIAMS: No.

MS. SINGH: Zaremberg?

MR. ZAREMBERG: No.

MS. SINGH: Zatkin?

MR. ZATKIN: No.

MS. SINGH: Decker?

(No audible response.)

MS. SINGH: Gallegos?

MR. GALLEGOS: Aye.

MS. SINGH: It is not adopted. The statement is not adopted. I called her name twice. She doesn't have to indicate yes or no.

MR. PEREZ: You have to call it three times.

MS. SKUBIK: Could the statement be reread?

MS. SINGH: It has not been adopted, Members. Mr. Chairman, do you have public comment?

MS. GRIFFITHS: Mr. Chairman, my question is a procedural one. In view of what's transpired, I'd like to request that the statement of the 15 members who signed the statement to be included in the letters submitted by Task Force members, I noticed that other statements were not required to be signed, but just typed on one.

CHAIRMAN ENTHOVEN: Fine. Okay. Thank you. All right. We'll move on to public comment. We have one speaker.

MS. SINGH: Mr. Chairman, that person has -- no longer wishes to speak. Is there any member of the public that would like to address this body for the last time?

CHAIRMAN ENTHOVEN: Before we break I wanted to present a prize to another person, and that is the skillful parliamentarian who successfully steered me through this difficult maze, and to thank Alice Singh for doing a great job.

MR. KERR: Whether we think that too little was done or too much was done, certainly a lot of work was done both by Alain and his Stanford staff and by Phil Romero and his Sacramento staff, and I would love to see some appreciation for the tremendous work they put in.

MS. SINGH: And we'd like to thank the Chamber. They've been a very gracious host for many of our meetings. Mr. Zaremberg, if you will echo that to your staff, we will appreciate it.

CHAIRMAN ENTHOVEN: The meeting is adjourned.

* * *

STATE OF CALIFORNIA)
) ss.
COUNTY OF ALAMEDA)

I, Jennifer Arroyo, CSR 10696, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witnesses and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this _____day of _____, 1998.

_____
Jennifer Arroyo, CSR #10696